Supreme Court, U.S.
FILED

93 1502 MAR 16 1994

OFFICE OF THE CLERK

No.

In the Supreme Court of the United States

October Term, 1993

Arthur Bradley Samura,
Petitioner,

v.

Kaiser Foundation Health Plan, Inc.,
The Permanente Medical Group, Inc., and
Kaiser Foundation Hospitals, Inc.

PETITION FOR WRIT OF CERTIORARI TO THE CALIFORNIA COURT OF APPEAL, FIRST APPELLATE DISTRICT, DIVISION ONE

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QUESTION PRESENTED

1. Does the federal Health Maintenance Organization Act allow federally qualified HMOs to charge their members fees for individual services in addition to monthly dues, if members are injured by third parties who financially compensate the member? 42 U.S.C. § 300e(b)(1)

PARTIES TO THE PROCEEDINGS

Petitioner Arthur Bradley Samura was plaintiff in the trial court, respondent at the California Court of Appeal, and petitioner to the California Supreme Court.

Respondents below are Kaiser Foundation Health Plan, Inc., The Permanente Medical Group, Inc., and Kaiser Foundation Hospitals, Inc. Each of them is part of a group informally known as "Kaiser-Permanente" that includes the following entities:

Kaiser Foundation Health Plan of the Northwest;
Kaiser Foundation Health Plan of Ohio;
Kaiser Foundation Health Plan of Colorado;
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.;
Kaiser Foundation Health Plan of Texas;
Kaiser Foundation Health Plan of Conn., Inc.;
Kaiser Foundation Health Plan of New York;
Kaiser Foundation Health Plan of North Carolina;
Kaiser Foundation Health Plan of Georgia, Inc.;
Kaiser Foundation Health Plan of Kansas City, Inc.; and, Kaiser Foundation Health Plan of Massachusetts, Inc.

(cont.)

Southern California Permanente Medical Group;
Northwest Permanente, P.C.;
Hawaii Permanente Medical Group, Inc.;
Ohio Permanente Medical Group, Inc.;
Colorado Permanente Medical Group, P.C.;
Permanente Medical Association of Texas;
Capital Area Permanente Medical Group, P.C.;
Northeast Permanente Medical Group, P.C.;
The Southeast Permanente Medical Group of Georgia, Inc.;
The Southeast Permanente Medical Group of North Carolina, P.A.; and,
Permanente Medical Group of Mid-America, P.A..

Kaiser Foundation Rehabilitation Center; and,
Kaiser Foundation Research Institute.

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PETITION FOR WRIT OF CERTIORARI TO THE CALIFORNIA COURT OF APPEAL, FIRST APPELLATE DISTRICT, DIVISION ONE

Arthur Bradley Samura respectfully petitions for a writ of certiorari to review the judgment and opinion of California Court of Appeal, First Appellate District, Division One.

OPINIONS BELOW

The opinion of the California Court of Appeal involving the construction and application of the federal Health Maintenance Act, 42 U.S.C. § 300e(b)(1) is reported at 17 Cal. App. 4th 1284 (App. 1-23). The statement of decision of the Superior Court of the State of California for the County of Alameda (Girard, J.) is unreported (App. 24-32). A related opinion of the United States District Court for the Northern District of California (Schwarzer, J.), remanding this case after removal, is reported at 715 F. Supp. 971 (N.D. Cal. 1989) (App. 33-38).

JURISDICTION

The judgment of the California Court of Appeal, First Appellate District, construing 42 U.S.C. § 300e(b)(1), was entered on August 17, 1993. Thereafter, on December 16, 1993, the California Supreme Court denied a timely filed Petition for Review (App. 39). It raised the question of the construction and application of 42 U.S.C. § 300e(b)(1). The jurisdiction of this court is invoked under 28 U.S.C. § 1257(a).

STATUTORY PROVISION INVOLVED

42 U.S.C. § 300e(b)(1) is set out in the appendix (App. 40-42).

STATEMENT OF THE CASE

Petitioner Arthur Samura had been a member of Kaiser-Permanente, a federally qualified Health Maintenance Organization (HMO), for ten years before he was injured in a non-work related auto accident. He received medical care from Kaiser for his injuries. He sued the other driver. Then Kaiser sent him a demand letter enclosing a copy of the third party liability (TPL) term from its member contract.[1] The TPL term provides that Kaiser members must pay "Non-Member Rates" for each service they are furnished if they are injured by a third party who financially compensates them. These charges are in addition to monthly member dues that were prepaid by or on behalf of members. The TPL term provides that Kaiser may collect a member's entire recovery, up to one-hundred percent of the sum paid by the third party, if the charges calculated according to Non-Member Rates equal or exceed the recovery.

Petitioner was surprised. He had read Kaiser's booklet, but he did not notice, or did not understand, the meaning of the TPL term. Petitioner believed that he was entitled to all of the basic health care he needed, without paying Non-Member Rates too, because he prepaid dues.

Petitioner filed a complaint against Kaiser in the Superior Court for the State of California for the County of Alameda. It alleged, on behalf of petitioner and the general public, that Kaiser's TPL term and associated practices violate California's Unfair Trade Business Practices Act, California Business and Professions Code

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1 Kaiser's one-thousand word-long TPL term is set out *in haec verba* in the Appendix (App. 43-46).

§ 17200, California's 'little FTC Act.' This law prohibits any unlawful, unfair or deceptive business practice. Recently, the California Supreme Court quoted with approval the California Attorney General's explanation of how unlawfulness is determined under the Unfair Trade Practices Act: "'[I]n essence, an action based on Business and Professions Code section 17200 to redress an "unlawful" business practices 'borrows' violations of other laws and treats these violations, when committed pursuant to business activity, as unlawful practices independently actionable under section 17200 et seq. and subject to the distinct remedies provided thereunder.'" *Farmers Ins. Exchange v. Superior Court*, 2 Cal. 4th 377, 383 (1992) (emphasis added).

HOW THE FEDERAL QUESTION WAS PRESENTED

On April 10, 1989, petitioner filed his First Amended Complaint alleging that Kaiser is subject to the federal HMO Act, and that Kaiser's TPL term violates the provisions and policy of the Act, in particular, 42 U.S.C. § 300e(b)(1) and, therefore, the TPL term is "unlawful" *per se* within the meaning of California's little FTC Act.

Trial to the court took place in one week in March, 1991. Petitioner cited to the HMO Act structure to show that TPL terms are unlawful. The HMO Act is composed of a general rule that HMOs must provide all health care in exchange for prepaid dues (fixed without regard to the frequency, extent, or type of services provided) followed by certain enumerated exceptions to this general rule. 42 U.S.C. § 300e(b)(1). TPL terms do not fit within the enumerated exceptions to

the general rule.

Petitioner also cited to the legislative history of 42 U.S.C. § 300e(b)(1) showing that Congress intended that HMOs operate on a prepaid basis to the greatest extent possible. Finally, petitioner cited to the history of the implementation of the HMO Act. Regulations permitting TPL terms were proposed, but ultimately not adopted, by the Department of Health, Education and Welfare, the agency that was delegated the power to implement the federal HMO Act (later succeeded by the Department of Health and Human Services).

On October 10, 1991, the trial court entered judgment. The court rejected petitioner's claim that Kaiser's TPL term and practices violate 42 U.S.C. § 300e(b)(1) (App. 28). The trial court concluded that 42 U.S.C. § 300e(b)(1) and its regulations do not expressly authorize, or prohibit, TPL terms, and, because Kaiser's TPL had not been disapproved by the Department of Health and Human Services, the TPL term was not unlawful (App. 22-23).

However, the court entered judgment for petitioner on other grounds, ordering Kaiser to rewrite its TPL term in plain English and include equitable limits on Kaiser's claim to 100% of an injured member's recovery (App. 24-32).[2] Kaiser appealed, and the court of appeal reversed the judgment in favor of petitioner (App. 1-23).

Petitioner cross-appealed from the trial court's ruling that the TPL term and practices do not violate the federal HMO Act. On August 17, 1993, the Califor-

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2 Petitioner's case against the third party had liability problems. He settled for only $2,500 for a badly broken arm, six weeks lost income, amounting to approximately $3,000, and hundreds of dollars in property damage. At trial, Kaiser waived its entire TPL claim against petitioner.

nia court of appeal denied petitioner's cross-appeal. The court of appeal ignored that Congress, through its enumerated exceptions, limited the HMOs' power to surcharge their members. The decision simply concludes that TPL terms are permissible because they are not expressly prohibited by 42 U.S.C. § 300e(b)(1). The court of appeal did not discuss rules of statutory construction, or the legislative history of the HMO Act and the evolution of the Act's regulations on which petitioner relied to show that the HMO Act prohibits TPL terms (App. 23).

Petitioner filed a timely Petition for Review to the California Supreme Court requesting review of whether Kaiser's TPL term violates the federal HMO Act. It was denied, without opinion, on December 16, 1993 (App. 39).

The issue of the meaning of the federal HMO Act was raised properly at each stage of the proceedings, and is appropriate for the exercise of the Court's discretionary certiorari jurisdiction because, "[d]espite the absence of a conflict, state court decisions involving the construction and application of federal statutes or treaties may be reviewed on certiorari where the questions is sufficiently important." R.L. STERN, E. GRESSMAN & S.M. SHAPIRO, SUPREME COURT PRACTICE at 238 (6th Ed. 1986). There is no independent state ground for the decision because California's little FTC Act "borrows" 42 U.S.C. § 300e(b)(1) exactly as it is, without change, to supply a standard for enjoining Kaiser's TPL practice as "unlawful."

REASONS FOR GRANTING THE PETITION

The main question here — whether the federal HMO Act prohibits HMOs from charging fees-for-services to injured members — is worthy of certiorari because it concerns an area of vital interest, health care, and it is important to over five hundred federally qualified HMOs nationwide, important to over thirty-three million persons who are members of federally qualified HMOs, and tremendously important to hundreds of thousands of injured members who face active TPL claims by their HMOs. The question also is important to the efficient administration of justice because TPL claims make the associated tort litigation more difficult to settle, consuming scarce judicial resources, especially as the amount of the TPL claim increases in proportion to the amount recoverable or recovered from the third party. Allocating of settlements equitably between HMOs and their members is difficult if not impossible, and a subsequent round of litigation often follows when the parties cannot agree on the proper allocation of recoveries.[3]

In Kaiser's own words, the question of whether TPL terms are enforceable is of "across-the-board con-

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3 There are substantial problems in apportioning recoveries between HMOs and their members because HMOs provide services, not indemnification. Kaiser's trial testimony revealed that it does not know how much it costs to provide services, and Kaiser adopts the fees of others to charge its members in TPL claims. Cases by insurers seeking reimbursement of sums paid are fraught with problems and burden courts. *See, e.g., Powell v. Blue Cross & Blue Shield*, 581 So.2d 772 (Ala. 1990); *Westendorf by Westendorf v. Stasson*, 330 N.W.2d 699 (Minn. 1983).

cern to California's health care community."[4] Numerous *amici curiae* echoed Kaiser's proclamation of the importance of the question in connection with petitioner's request for review by the California Supreme Court.[5] The California Court of Appeal's approval of Kaiser's TPL term mutates the HMO-member relationship in which consumers buy health care on a fixed prepaid basis and shift the financial risk to their HMOs into something quite different. Contrary to the law, the Opinion allows HMOs to charge their members Non-Member Rates based on the frequency, extent or kind of health service actually furnished to a particular member. Finally, because neither the HMO Act nor its regulations authorize TPL terms, there are no reasonable controls on the surcharges federally qualified HMOs impose on their injured members. *See Zinman v. Shalala*, 835 F. Supp. 1163 (N.D. Cal. 1993).

Certiorari should be granted, the HMO Act properly interpreted, and the decision below reversed.

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4 Kaiser's Answer to Plaintiff-Respondent's Petition for Rehearing in the California Court of Appeal, at p. 1. Kaiser offers HMO memberships in sixteen states, and the interpretation of the HMO Act is equally important in the other states.

5 Letter briefs were submitted emphasizing the importance of TPL claims to HMOs and insurers by the following entities: Blue Shield of California; The Prudential Insurance Company of America; FHP [Family Health Plan] Health Care; Southern California Permanente Medical Group; California Chamber of Commerce, Association for California Tort Reform; California Manufacturers Association, and, joining in one letter brief were Blue Cross of California, California Care, Guardian Life Insurance Co. of America, Health Net, Inc., Humana Health Plans, I.T.T. Hartford Life Insurance Co., John Hancock Insurance Company, Massachusetts Mutual Life Insurance Co., Nationwide Life Insurance Co., Pacific Mutual Life Insurance Co., Phoenix Home Life Mutual Insurance Co., Principal Mutual Life Insurance Co., Washington Nation Insurance Co.

A. Many Persons Are Directly Affected By The Issue Presented.

"Kaiser-Permanente" is the informal name for a group of related organizations that comprise the largest nongovernmental health care delivery system in the world. In 1992, Kaiser's nationwide enrollment was 6.6 million members. The TPL term is a non-negotiable part of *every* Kaiser contract.

In 1991, at the time of trial, Kaiser's Northern California region in which petitioner is enrolled had 2.4 million members and Kaiser in that region alone was asserting 25,000 active TPL claims. Kaiser also is prosecuting scores of suits against its members (and their attorneys in the members' actions against the third party wrongdoers) in state and federal courts in northern California. Assuming that TPL enforcement is about equal throughout the Kaiser system, then Kaiser is asserting well over a half-a-million active TPL claims against members in sixteen states and in the District of Columbia.

"The Federal HMO Act of 1973 . . . helped HMOs grow from merely an idea in California, into a nationwide industry serving over 33 million enrollees. The Act established the federal qualification process that has become a seal of approval for over 500 plans." Figa & Tag, *Redefining Full and Fair Disclosure of HMO Benefits and Limitations*, 14 SETON HALL LEG. J. 151, 152 (1990). The proper interpretation of the rights and duties of HMOs and their members under the federal HMO Act is of substantial importance to the many persons affected.

B. TPL Claims Do Not Make Dollars Or Sense.

1. The financial contribution from TPL claims to HMOs is minuscule.

The common theme of Kaiser and its *amici* in the California Supreme Court was that TPL claims are a significant aspect of cost containment because such claims generate revenue from third party wrongdoers, and that revenue in turn reduces the price of HMO memberships to the public. The monthly cost of Kaiser membership, at the time of trial in 1991, for an individual was $119.50; for a two-person family, $237.00; and, for a family of three or more, $314.55.

In fact, revenue from TPL claims does not significantly reduce the cost of memberships to the public. Kaiser collected pursuant to its TPL term the equivalent of fifteen cents to twenty-five cents per member per month from 1988 to 1990. Blue Shield of California, one of Kaiser's *amici* below, collected slightly less than twenty cents per member per month. Moreover, these twenty-five cents and twenty cents per member per month contributions are gross amounts, not adjusted to reflect the cost of implementing the TPL practice, further reducing the *de minimis* contribution of revenue from TPL claims. These amounts do not include the additional costs to the public if settlements of underlying personal injury cases are impeded by TPL claims, or if subsequent litigation between HMOs and injured members arises because of disputes about apportionment of settlements.

Eliminating Kaiser's TPL term would not affect sales of memberships. A group-accounts marketing

supervisor of Kaiser confirmed what is obvious, testifying at trial that an increase of twenty-five cents per member per month in the rates would not "make or break" any sale. Recently, a proposal to charge registration fees to federal HMOs drew objections from the HMO industry because the fees would increase the HMO's administrative cost by one-percent, and thereby make HMO membership more expensive. The regulators stated that a possible one-percent increase in member dues that might result was "negligible." 52 Fed. Reg. 22311, 22318 (1987). TPL revenue to Kaiser of twenty-five cents per member per month is less than one-quarter of one-percent of its operating budget, and represents less than one-quarter of one-percent of an individual's monthly dues.

Moreover, the real source of soaring health care costs appears to be unnecessary care.[6] Health care cost containment measures are increasingly directed towards creating incentives for providers to furnish only necessary care and away from fees-for-services charges. Couch, *Employers' Role in Improving Medical Care Value*, 14 SETON HALL LEG. J. 65, 70-71 (1990). TPL terms neither help reduce unnecessary care nor significantly reduce the cost of health care to the public.

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6 Studies indicate that as much as 25% of hospital care is unnecessary. Hirshfeld, *Should Third Party Payors of Health Care Services Disclose Cost Control Mechanism to Potential Beneficiaries*, 14 SETON HALL LEG. J. 115, n.3 (1990).

2. TPL claims against injured members contravene the HMO Act because they render dues payments illusory and cause members great harm.

In the best of circumstances, injured members are able to collect full compensation for their losses from third party wrongdoers. Each of Kaiser's arguments in support of its TPL claim practice assumes that a full recovery is common, when in fact full recovery is most unusual. In the usual case, because of various factors such as underinsurance, compromise or comparative fault, tort victims do not receive full compensation for their losses. Undercompensation makes fair apportionment between the HMO and its injured members difficult, if not impossible. *See*, the basis of the Department of Health, Education and Welfare's refusal to allow TPL terms: "in tort settlements, it is often not possible to determine the portion of settlements allocable to medical costs." 39 Fed. Reg. 37309 (1974). Further, tort victims almost always pay their attorneys a percentage of the whole, frequently one-third or more, so even a "fully" compensated tort victim is not made whole. *See, Annotation*, 77 A.L.R. 3d 415, 421 (1977).

HMO members expect their HMO to take care of their health care needs in exchange for prepaid dues, and they do not expect to have to pay surcharges from their tort recoveries. As the California court of appeal concluded, the TPL term "represents a departure from the general pattern of the health service agreement that may arguably result in surprise." (App. 15). The problems inherent in HMO TPL claims simply show the wisdom of the Congressional decision to prohibit such terms. Further, the economics of TPL terms do

not justify fashioning a judicial exception to the HMO model Congress has selected. The Court should grant review and ensure that federally qualified HMOs satisfy the expectations of Congress and the public.

C. This Court Should Interpret The HMO Act So The Public Receives Benefits Which It Reasonably Expects And To Which It Is Entitled.

The prohibition against TPL terms in HMO agreements is inherent in the structure and content of the HMO Act. The Act states the general rule that health care shall be provided in exchange for prepaid member dues fixed without regard to the frequency, extent, and kind of services actually furnished. Then the statute states specific exceptions to the general rule. 42 U.S.C. § 300e(b)(1). Where a statute states a general rule and specific exceptions, no other exceptions are allowed. *Andrus v. Glover Construction Co.*, 446 U.S. 608, 616-617 (1980); *Boudette v. Barnette*, 923 F.2d 754, 756-757 (9th Cir. 1991).

The prohibition against TPL terms is expressed in the HMO Act's regulations as well. "An HMO may not offer to provide or arrange for the provision of basic health services on a prepayment basis which . . . are limited as to time and cost *except in a manner prescribed by this subpart.*" 42 C.F.R. § 417.102(e) (emphasis added); *see id.* at § 417.104(a). The regulations do not allow TPL terms calling for payments based on the time and cost of treatment.

The failure of the courts below to correctly interpret and apply the federal HMO Act calls for certiorari.

D. The Legislative History Of The HMO Act Fully Supports The HMO Act's Prohibition Against TPL Terms.

In 1973, Congress passed the HMO Act to increase consumer options by encouraging development of a health care delivery system operating on a prepaid basis in competition with traditional fees-for-services insurance. S. REP. No. 93-129, 93rd Cong., 1st Sess., *reprinted in* 1973 U.S. CODE CONG. & ADMIN. NEWS 3033, 3039. The original Senate bill did not allow HMOs to charge members more than prepaid dues; HMOs could not even charge nominal co-payments for selected services. S. REP. No. 93-621, 93rd Cong., 1st Sess., *reprinted in* 1973 U.S. CODE CONG. & ADMIN. NEWS 3126.[7]

The law as enacted in 1973 allowed HMOs to charge nominal co-payments, but those surcharges were to be the "absolute upper limits" on additional charges to members. S. REP. No. 93-621, 93rd Cong., 1st Sess., *reprinted in* 1973 U.S. CODE CONG. & ADMIN. NEWS 3126. And, in keeping with the basic premise that HMOs must provide all basic health care in exchange for periodic payments fixed in amount "without regard to the frequency, extent or kind of health service actually furnished" 42 U.S.C. § 300e(b)(1)(B), HMOs must reimburse members for expenses of necessary emergency care provided by non-plan providers. S. REP. No. 93-621, 93rd Cong., 1st Sess., *reprinted*

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7 *See e.g.*, Rosoff, *The Federal HMO Assistance Act*, 13 AM. BUS. L.J. 137, 155 (1975): "Greatly aggravating the marketing difficulties inherent in providing a comprehensive benefit package is the HMO Act's limitation on copayments. . . . The Senate bill, true to its purist philosophy, permitted no copayments whatsoever."

in 1973 U.S. CODE CONG. & ADMIN. NEWS 3129.

The Department of Health, Education and Welfare was charged with implementing the HMO Act. HEW proposed regulations that expanded the revenue sources for HMOs. The proposed regulations allowed that an HMO (1) could impose co-payments at the time services were provided, 42 C.F.R. §§ 110.103(d), 110.104(b); (2) could exclude coverage for inpatient benefits where other insurance was available, *id.* at § 110.108(b)(11); (3) could exclude coverage where workers' compensation would cover the services, *id.*; and, (4) must pursue TPL claims where third parties were legally liable for the supplemental services rendered to the member, *id.* at § 110.104(c). 39 Fed. Reg. 16421, 16424-16426 (1974).

However, after the comment period, HEW withdrew the regulation allowing HMOs to exclude coverage for members who had other insurance, or who were entitled to worker's compensation benefits. 39 Fed. Reg. 37308, 37209 (1974). Instead, the regulation finally adopted stated the general rule that HMOs must provide all basic health care, but allowed HMOs to seek reimbursement from worker's compensation payors where not barred by state law. 42 C.F.R. §§ 110.105(b); 110.106(c), *see* 39 Fed. Reg. 37209, 37314 (1974). The proposed regulation allowing TPL terms was entirely deleted, in part, because of the inability of HMOs to identify other payment sources in every case, and in part because "in tort settlements, it is often not possible to determine the portion of settlements allocable to medical costs." *Id.* at 37309.

In 1978, exceptions were added to the HMO Act's general rule that federal HMOs must provide services for prepaid dues (fixed without regard to the frequency and kind of services needed) and nominal copayments.

HEALTH MAINTENANCE ORGANIZATION ACT of 1978, Pub. L. No. 95-559, § 300e, 92 Stat. 2139 (1978). The amendments permitted HMOs to seek reimbursement from worker's compensation payors and other insurers, and limited the HMOs' duty to provide services during wartime or disasters. *Id.* No exception was added allowing HMOs to seek reimbursement from their member's tort recoveries.[8] And, because the TPL term does not fit within the specific exceptions to the HMO Act's general rule, TPL terms are prohibited. *Andrus v. Glover Construction Co.*, 446 U.S. 608, 616-617 (1980).

In 1981, The HMO Act was amended to change the community rating system. This change allowed HMOs to set different premium rates for different groups. THE OMNIBUS BUDGET RECONCILIATION ACT of 1981, Pub. L. 97-35, 95 Stat. 575 (1981). Congress did not authorize HMOs to impose TPL terms, even though such terms might affect the rates charged by HMOs. Congress did not increase the limited, specific exceptions to its mandate that HMOs provide all basic health care on a prospective basis. 42 U.S.C. § 300e(b)(1). At the very same time, Congress amended the Medicaid

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8 In stark contrast, the HMO Act was amended to clearly express the HMO member's right of reimbursement *from the HMO. Id.*

The legislative history of the 1978 amendments shows that Congress authorized "narrow limitations" that "could only apply" to the circumstances described in the amendment. S. REP. No. 95-837, 97th Cong., 1st Sess., 2, 19, *reprinted in* 1978 U.S. CODE CONG. & ADMIN. NEWS 4935, 4936, 4966. Congress also limited the Secretary's discretion to authorize exceptions in addition to those set forth in the HMO Act. *Id.* at 9-10, 1978 U.S. CODE CONG. & ADMIN. NEWS at 4943-4944.

The Congressional debate also reflects that Congress intended only very limited, well-defined, express exceptions to the general rule that HMOs operate on revenue from fixed prepaid dues. *E.g.* 125 CONG. REC. 22127, 32216, 37063 (1978).

Act to limit the state's duty to "collect third party liabilities" in certain instances. THE OMNIBUS BUDGET RECONCILIATION ACT of 1981, Pub. L. 97-35, 95 Stat. 816. These concurrent amendments show that Congress will be precise about TPL terms. The absence of an exception for "third party liabilities" in 42 U.S.C. § 300e(b)(1) shows that federally qualified HMOs may not impose charges on a fees-for-services on injured members through TPL terms.[9]

E. The Decision Cannot Be Sustained On Independent State Grounds.

The California court of appeal decided that TPL terms do not violate the federal HMO Act, and that, as a result, Kaiser's TPL term does not violate California's little FTC Act (App. 22-23). There are no independent state grounds for the decision, even though it refers to state law, because the state and federal grounds involved in the decision are inextricably interwoven. *Enterprise Irrigation District v. Farmers Mutual Canal Co.*, 243 U.S. 157, 164 (1917).

Kaiser argued below (and is expected to reassert) a contention that further analysis of the meaning of the federal HMO Act is inappropriate because California's little FTC Act cannot rest on (or "borrow") the federal HMO Act to establish a standard of unlaw-

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9 Here again, the legislative history of the 1981 amendments fully supports a plain reading of the HMO Act. The amendments were passed to make HMOs more competitive. H.R. REP. NO. 97-158, 97th Cong., 2nd Sess., at 1, 13 (Vol. II), *reprinted in* 1981 U.S. CODE CONG. & ADMIN. NEWS 1180. However, Congress did not try to make HMOs more competitive by adding to the limited, exceptions to its rule that HMOs provide all basic health care on a prospective basis. *Id.* at 6-7, 1981 U.S. CODE CONG. & ADMIN. NEWS at 1174.

fulness. Kaiser's contention is not based on state law grounds but instead blurs together federal questions of preemption and supremacy. Essentially, Kaiser erroneously contends that the remedies of the little FTC Act are preempted or unavailable wherever the "borrowed" federal law does not provide a private right of action.[10]

1. California's little FTC Act reaches *any* unlawful conduct, including violations of federal law.

California's little FTC Act prohibits ""anything that can properly be called a business practice and that at the same time is forbidden by law."'[Citation.]" *Farmers Ins. Exchange v. Superior Court, supra*, 2 Cal. 4th at 395; *accord, Bank of the West v. Superior Court*, 2 Cal. 4th 1254, 1264, 1266-1267 (1992). California courts are expressly authorized to enjoin violations of state or federal law that are harmful to consumers. California law provides that "violation of any law of this state or *any federal law* . . ." may be enjoined. Cal. Bus. & Prof. Code § 321 (emphasis added). Thus, there is no state law ground that prevents California's FTC Act from reaching Kaiser's violations of the federal HMO Act.

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10 Kaiser's contention that California's little FTC Act cannot "borrow" the federal HMO Act to supply a standard for determining whether Kaiser's TPL term is "unlawful" does not concern an independent state ground for the decision. However, Kaiser's contention is addressed at this point because it cloaks its argument in state law garb, creating the appearance of issues of state law rather than issues of federal preemption.

The broad scope of California's little FTC Act simply mirrors the federalism that forms our country. "We start with the premise that nothing in the concept of our federal system prevents state courts from enforcing rights created by federal law." *Dowd Box Co. v. Courtney*, 368 U.S. 502, 507-508 (1962). When Congress enacts a law, it establishes a policy for each of the states. "That policy is as much a policy of [the State] as if the act had emanated from [the State's] own legislature, and should be respected accordingly in the courts of the State." *Second Employer's Liability Cases*, 223 U.S. 1, 57 (1911).

Accordingly, California courts adopt, refer to, and enforce the policies articulated in federal law. In, *Solorzano v. Superior Court*, 10 Cal. App. 4th 1135 (1993), the court used California's little FTC Act to enjoin violations of Medicare law. 42 U.S.C. § 1395, *et seq*. In another case, the court used the requirements of the federal HMO Act to issue an injunction safeguarding the independence of an HMO. *Health Maintenance Network v. Blue Cross of So. Cal.*, 202 Cal. App. 3d 1043 (1988).[11] Federal law is used to establish the standard of due care that juries apply to decide some tort actions. Cal. Evid. Code § 669; *Fagerquist v. Western Sun Aviation, Inc.*, 191 Cal. App. 3d 709, 717-720 (1987). Federal law so animates some state law actions that juries may independently measure whether a business has complied with federal regulations — even where a

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11 Other states also use the standards articulated in federal laws to define proper business conduct. *See In re Scrimpsher*, 17 Bankr. 999, 1009 (1982) (action based on thefederal Fair Debt Collection Practices Act, 15 U.S.C. § 1692); *Dial Corp. v. Manghnani Inv. Corp.* 659 F. Supp. 1230 (D.Conn.1987) (action based on Lanham Trade Mark Act, 15 U.S.C. § 1141.)

federal agency with exclusive jurisdiction to enforce the federal law has certified compliance. *Elsworth v. Beech Aircraft*, 37 Cal. 3rd 540, 547-552 (1984).

2. The remedies provided by California's little FTC Act do not conflict with the enforcement scheme in the federal HMO Act, even though the federal HMO Act does not provide a private right of action.

Kaiser's preemption argument turns on the premise that Samura's action uses state law to create a private right of action in the federal HMO Act. However, the lack of a private right of action in the federal HMO Act is immaterial because petitioner does not seek relief under the HMO Act. As Judge Schwarzer explained rejecting Kaiser's removal petition when it asserted federal question jurisdiction based on the HMO Act claim: "The amended complaint did not change the nature of the underlying claim. The reference to the federal HMO Act merely provides an added standard governing application of the Unfair Practices Act." *Samura v. Kaiser Foundation Health Plan, Inc.*, 715 F. Supp. 971, 972 (N.D. Cal. 1989) (App. 38).

Actions under California's little FTC Act do not seek remedies provided in the underlying federal statute. Instead they invoke remedies provided in the state Act itself, principally injunctive relief needed to protect the public welfare. As a result, the lack of a private right of action in the "borrowed" law is irrelevant to the propriety of an injunction under California law. *Committee on Children's Television v. General Foods Corp.*, 35 Cal. 3rd 197, 210-211 (1983); *see also Farm-*

ers Ins. Exchange v. Superior Court, supra, 2 Cal. 4th at 395 ("Unfair Practices Act applies in many situations in which no administrative process is available to address the challenged practice.").

Kaiser's preemption argument is based entirely on the lack of a private right of action in the federal HMO Act. However, preemption is to be determined by the language and purpose of the underlying federal law. *Morales v. Trans World Airlines, Inc.*, ___ U.S. ___; 112 S.Ct. 2031; 119 L.Ed.2d 157 (1992). The most concise response to Kaiser's contention that preemption will be implied from the lack of a private right of action alone is found in *Solorzano v. Superior Court*, 10 Cal. App. 4th 1135 (1993). The defendant HMO in *Solorzano* "contend[ed] that the mere existence of a federal regulatory scheme makes state injunctive relief inappropriate under general principles of equity. The cases [cited by the HMO] are inapposite because, unlike the case at bench, both deal with fields absolutely and entirely preempted by federal law (immigration and Indian affairs.)" *Solorzano, supra*, at 1148, n. 14.[12]

Mischief would result if the lack of a private right of action, standing alone, resulted in the preemption of state laws enacted to protect public welfare. For instance, Congress did not provide a private right of action under the FTC Act. Nonetheless, most States, including California, adopt FTC regulations and rulings as the standard for violations under their own little

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[12] The defendant HMO in *Solorzano* and Kaiser both rely on the same two cases involving immigration and Indian affairs: *I.e., Naegele OutdoorAdvertising Co.*, 38 Cal. 3d 509 (1985) and *Diaz v. Kay-Dix Ranch*, 9 Cal. App.3d 588 (1970). These cases are also referred to elliptically in the court of appeal's opinion (App. 23).

FTC Acts. *See People ex rel Mosk v. National Research Co. of Cal.*, 201 Cal.App.3d 765 (1962); *Barquis v. Merchant's Collection Assn.*, 7 Cal. 4th 94, 109-111 (1972). These important state laws are not preempted simply because Congress did not provide a private right of action in the federal FTC Act.

3. The preemptive scope of the federal HMO Act is express and narrow.

The HMO Act expressly provides that only state laws that thwart the formation of HMOs are preempted. 42 U.S.C. § 300e-10. Indeed, every state law preempted by the HMO Act must be identified and enumerated. *Id.* Moreover, Congress expressly encourages the states to adopt the standards of the HMO Act. The "Federal HMO Act sets a policy that HMOs are to be encouraged and held to certain standards." S. Rep. No. 100-204, 100th Cong., 2ndSess. (p. 11), *reprinted in* 1988 U.S. CODE CONG. & ADMIN. NEWS 3239. State laws consistent with the standards of the federal HMO Act are not to be preempted. (*Id.*)

The purposes of the HMO Act are advanced by state laws that adopt and ensure compliance with the standards of the Act. As the court of appeal poignantly concluded in rejecting the analogous argument that Medicare preempts actions based on California's little FTC Act: "Congress clearly recognized the need for state and local assistance in regulating the marketing of HMOs . . . and, quite the opposite of intending preemption, appears to have intended a call to the states (and private parties) for all the help it can get." *Solorzano v. Superior Court, supra*, 10 Cal. App. 4th at 1149.

California's Little FTC Act merely protects Californians from HMOs that fail to meet the standards articulated by Congress; it does not hinder HMO formation or federal enforcement efforts, and it is not preempted.

CONCLUSION

A key concern of Congress when it passed the federal HMO Action 1973 was to foster an alternative health care delivery system to the traditional 'fees-for-services' method. To satisfy this concern, the HMO Act provides that HMOs shall accept the financial risk of health care of their members on a prospective basis in exchange for prepaid, periodic payments only. 42 U.S.C.§ 300e(b)(1)(A). HMOs must determine the amount of periodic payments without regard to the health care services actually furnished to any individual member. 42 U.S.C. § 300e(b)(1)(B). In addition, HMOs may charge nominal copayments at the time services are rendered. *Id.*

In 1978, Congress approved specific exceptions to the general rule of 42 U.S.C. § 300e(b)(1); the exceptions allow HMOs to coordinate insurance benefits and, if state law permits, HMOs may charge the workers' compensation insurance carrier or employer. There is no authorized exception allowing HMOs to pursue "third party liabilities."[13] Further, the limited discretion granted the Secretary of HHS (then HEW) does not include the power to expand on the exceptions enumerated in the HMO Act.

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13 Compare HMO Act with Medicaid. 42 U.S.C. §300e(b)(1); 42 U.S.C. §1396a(a)(25).

TPL terms substantially undermine the purpose of the HMO Act. Such terms do not make health care significantly more affordable to the public, but may — and often do — inflict harsh or unconscionable results on individual injured members. The California Court of Appeal erred when it authorized an exception for TPL terms that should not have been read into the HMO Act. The Opinion ignored the HMO Act's structure, and set a precedent that essentially allows HMOs across the country to impose any conditions on their members not expressly prohibited by law.

This petition for a writ of certiorari should be granted.

Respectfully submitted.

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MARCH 1994

Supreme Court, U.S.
FILED
931502 MAR 16 1994
OFFICE OF THE CLERK

No.

In the Supreme Court of the United States

October Term, 1993

Arthur Bradley Samura,
Petitioner,

v.

Kaiser Foundation Health Plan, Inc.,
The Permanente Medical Group, Inc., and
Kaiser Foundation Hospitals, Inc.

APPENDIX TO PETITION FOR WRIT OF CERTIORARI TO THE CALIFORNIA COURT OF APPEAL, FIRST APPELLATE DISTRICT, DIVISION ONE

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APPENDIX TO PETITION FOR CERTIORARI

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1. *Samura* v. *Kaiser Foundation Health Plan, Inc.* 17 Cal. App. 4th 1284; 22 Cal.Rptr. 2d 20; (Aug. 1993)

ARTHUR BRADLEY SAMURA, Plaintiff and Appellant, v.

KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants and Appellants.

Nos. A055730, A057515.
California Court of Appeal,
First Appellate District,
Division One.
Decided Aug 17, 1993.

COUNSEL

Manuel Glenn Abascal and Kathy S. Abascal for Plaintiff and Appellant.

Kennedy P. Richardson, Mark Palley and Lillian F. Hamrick for Defendants and Appellants.

OPINION

NEWSOM, J. — The Kaiser Foundation Health Plan, Inc., The Permanente Medical Group, Inc., and Kaiser Foundation Hospitals (hereafter Health Plan or Kaiser) appeal a judgment of the Alameda County Superior Court requiring extensive changes in the third party liability provision in service agreements with members. The theories alleged in the original complaint, filed by the plaintiff, Arthur Bradley Samura, on November 20, 1985, were greatly expanded in a first amended complaint filed about three and one-half years later. This amended complaint states a multifaceted legal challenge to the third party liability provision,

together with associated administrative practices, and seeks injunctive relief on behalf of Samura and other Health Plan members similarly situated pursuant to Business and Professions Code sections 17200 and 17203.

Following trial, the court issued an order on May 31, 1991, granting the relief that is the subject of this appeal. At Health Plan's request, it subsequently delivered a statement of decision clarifying the legal basis for the order. The provisions of the order were incorporated in a judgment, filed on October 10, 1991, from which Kaiser now appeals. Samura filed a cross-appeal claiming the right under state and federal law to an order enjoining the administration of the third party liability provision in any form.

Health Plan is a nonprofit health maintenance organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Health & Saf. Code, § 1340 et seq., hereafter Knox-Keene Act) and qualified under the federal Health Maintenance Organization Act of 1973. Like other health maintenance organizations, it provides health care services, in consideration for the payment of monthly dues, pursuant to service agreements with individual members and group service agreements with employers and union trust funds. The individual and group service agreements contain certain standard limiting conditions, including the third party liability provision at issue here. Health Plan does not itself provide medical care but rather contracts with the other defendants, The Permanente Medical Group, Inc., and Kaiser Foundation Hospitals, for the actual health care services.

The third party liability provision provides that, if a member receives medical services under the service agreement for an injury caused by a third party and

subsequently recovers a settlement or judgment a compensation for the injury, the member will pay Health Plan for the services from the proceeds of the settlement or judgment. A separate schedule establishes the fees for the medical services.[1] The provision gives the Health Plan "a lien on the settlement or judgment" for the purpose of collecting its charges. As a means of enforcing the lien, subdivision 6C(1)(d) of the provision gives Health Plan a right of subrogation against the third party, and subdivision (e) accords priority to the Health Plan lien in payment of the proceeds of the settlement or judgment. Samura has abandoned his challenge to the subrogation provision in this suit, choosing to pursue it in a separate lawsuit. This appeal thus concerns the provisions of subdivision (e) and related administrative practices.

Subdivision (e) provides: "Health Plan (or its designee) shall be entitled to the payment, reimbursement, and subrogation as provided in this Section C(1) regardless of whether the total amount of the recovery of the Member (or his or her estate, parent or legal guardian) on account of the injury or illness is less than the actual loss suffered by the Member (or his or her estate, parent or legal guardian). The proceeds of any judgment or settlement obtained by Health Plan (or its designee) or the Member (or his or her estate, parent or legal guardian) on account of the injury or illness shall first be applied to satisfy Health Plan's (or its designee's) claims, liens, and other rights under this Section C(1)."

The principal features of the third party liability provision are summarized in a pamphlet, entitled "Disclo-

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[1] The reasonableness of the fees is not at issue here as respondent abandoned his challenge to the fee schedule in the lower court.

sure Form & Evidence of Coverage," which is given to all members. In a concisely written paragraph, Health Plan again claims a lien on the proceeds of a settlement or judgment in the full amount of its charges.[2] Health Plan collects its charges under this provision through a third party liability department that sends an array of standard letters to members and their attorneys. Upon learning that a member is pursuing a claim against a third party, the department sends the member a "medical payment order" itemizing the charges for medical services rendered and notifying the member of Health Plan's right of reimbursement. An accompanying letter sent to the member's attorney states that, if the bill is paid promptly in full, Health Plan will bear a pro rata share of the member's attorney fees.[3] When the third party claim results in a re-

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2 "If injury or illness is claimed to be caused by any act or omission of a third party, services and other benefits are furnished or arranged by Medical Group physicians and Kaiser Permanente medical facilities at non-member rates. Payment is the member's responsibility, except that the member is not required to pay any portion of such charges for services which is in excess of the total amount collected from or on behalf of the third party on account of such acts or omissions, whether by settlement or judgment and Health Plan (or its designee) shall have a lien on the settlement or judgment for that purpose. At Health Plan's (or its designee's) request, the member (or his/her estate, parent or guardian) shall execute a lien form(s) directing his or her attorney or the third party to make payments to Health Plan (or its designee). In the event that Health Plan is required to institute legal action to enforce its lien, the member shall reimburse Health Plan for the reasonable costs of collection, including attorney's fees."

3 The letter sent to Samura's attorney stated: "It is our current policy to allow a reduction of our bill if the net amount due is promptly paid in full. The reduction is on a pro rata basis, equal to the contingency percentage charged to your client. The reduction does not apply to an agreed upon compromise of our claim, nor does it apply to any supplemental charges previously paid by the member."

covery through a settlement or judgment, the department ordinarily demands full payment of the charges, reduced only by a pro rata share of the attorney's contingency fee. But in the event that the recovery does not adequately compensate the member, the department may express a willingness to negotiate a further reduction in its claim. A standard letter states: "B) If liability problems compel the plaintiff or his attorney to compromise a claim for a figure substantially below the reasonable norm, our charge may be negotiated in a related fashion. [¶] C) If the plaintiff or his attorney is compelled to accept a final recovery which is totally disproportionate to the amount of damages and severity of injury (due to liability problems or inadequate insurance coverage), our third party reimbursement may be negotiated further."

The manager of the third party liability department testified that, as a rule of thumb, the department declines to negotiate a reduction of its charges if the tort recovery is three times the amount of its bill. The critical considerations, however, are the relation of the tort recovery to the member's economic losses, such as lost wages or lost earning capacity, and the prospect of "significant on-going" future medical costs. In some cases, the department will waive its rights to reimbursement entirely. As an example of a case in which it would consider waiving its rights, the manager used the following hypothesis: if the member is billed for $ 20,000 but recovers only $ 15,000 and "if the future medical is going to be $ 100 thousand and he's now a paraplegic and will never be able to return to work, not only will we probably significantly consider reducing the case, but waiving our rights to reimbursement." Even though he did not present such an extreme case, the department waived Samura's claim in accordance with its

"normal approach" because his recovery was less than his lost wages.

The order on appeal enjoins Health Plan "to clarify and explain the TPL [third party liability] terms in its agreements as follows: [¶] 1. Rewrite the TPL term in plain English and give greater prominence to the term in the contract. [¶] 2. Include a provision in the contract that standardizes and clarifies the method of reducing the amount of its claim if a member is not adequately compensated by a settlement agreement in third party litigation and include a provision in the TPL term for determining whether or not a member is adequately compensated. [¶] 3. Provide in the contract that [Health Plan] will share pro rata in the costs of litigation and attorney fees. [¶] 4. Refrain from calling the TPL term a 'reduction.' [¶] 5. Inform members in the medical payment order that [Health Plan] will share pro rata in litigation costs and in attorney fees. [¶] 6. Inform members in the medical payment order that [Health Plan] may reduce the amount of its claim if the member is not adequately compensated. [¶] 7. Refrain from combining the medical payment order with a medical information release authorization form. [¶] 8. Refrain from including any representations that the TPL term excludes or reduces coverage in the contract or standard form letters to members and/or their attorneys. [¶] 9. Standardize form letters regarding the TPL term to ensure that all members are informed of [Health Plan's] practice of reducing its claim to share pro rata in costs of litigation and attorney fees."

(1a) As it purports to enjoin unfair competition pursuant to Business and Professions Code section 17203, the propriety of the order depends on the definition of unfair competition in Business and Professions Code section 17200. The term was there defined to include

any "unlawful, unfair or fraudulent business practice."[4] "California courts have consistently interpreted such language broadly. An 'unlawful business activity' includes ' "anything that can properly be called a business practice and that at the same time is forbidden by law." ' " (*People* v. *McKale* (1979) 25 Cal.3d 626, 632 [159 Cal.Rptr. 811, 602 P.2d 731]; *Barquis* v. *Merchants Collection Assn.* (1972) 7 Cal.3d 94, 113 [101 Cal.Rptr. 745, 496 P.2d 817].)

As the statement of decision makes clear, the order is largely premised on alleged violations of the Knox-Keene Act, but paragraph 2—by far the most important provision—presents other issues of substantive law. The paragraph implies that the third party liability provision cannot be validly enforced against members who are not "adequately compensated" by the tort recovery from the third party causing their injury. We will first examine the case law in point.

With the exception of two out-of-state decisions which we have no reason to follow, the courts have upheld third party liability provisions according to their terms. In *Block* v. *Cal. Physicians' Service* (1966) 244 Cal.App.2d 266 [53 Cal.Rptr. 51], which concerned the service agreement of a health maintenance organization like Health Plan, the court rejected a challenge to a third party liability provision as being an assignment of a cause of action for personal injuries. (Accord, *Lee* v. *State Farm Mut. Auto. Ins. Co.* (1976) 57 Cal.App.3d 458, 465-466 [129 Cal.Rptr. 271].) Although the Block decision did not consider the enforceability of the provision against a beneficiary receiving inadequate com-

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[4] As amended, the code currently provides for any "unlawful unfair or fraudulent business act or practice." (Stats. 1992, ch. 430, § 2.)

pensation from the third party, this issue was addressed by *Travelers Indem. Co.* v. *Ingebretsen* (1974) 38 Cal.App.3d 858 [113 Cal.Rptr. 679], in the closely analogous context of a subrogation clause. Property insurance companies there asserted third party claims against a judgment partially compensating homeowners for losses sustained in a landslide. The court rejected a claim that the insurance companies should be denied any recovery until the homeowners were fully compensated for the losses. Under the circumstances of the case, it held that the "the insurer should be entitled to subrogation without regard to whether the insured has first been 'made whole.'" (*Id.* at p. 866.)

Other jurisdictions have enforced third party liability provisions against undercompensated beneficiaries. *In re Estate of Scott* (1991) 208 Ill.App.3d 846 [153 Ill.Dec. 647, 567 N.E.2d 605], upheld such a provision even though it served to deplete a grossly inadequate recovery for a disabling injury. Dismissing an argument that the provision was "inequitable," the court held: "This is not a case based in equity, but rather on contractual terms." (*Id.* at p. 607.) Again, *Sargeant* v. *Local 478 Health Benefits & Ins. Fund* (D.Conn. 1990) 746 F.Supp. 241, found no authority in Connecticut law for qualifying an insurer's right to enforce a third party liability provision. A line of decisions applying federal substantive law under the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1001 et seq.) has similarly enforced third party liability provisions where the beneficiary claimed to be inadequately compensated by the recovery from the third party. (*Molina* v. *Retail Clerks Unions etc. Benefit Fund* (1980) 111 Cal.App.3d 872 [168 Cal.Rptr. 906]; *Provident Life and Acc. Ins. Co.* v. *Linthicum* (W.D.Ark. 1990) 743 F.Supp.

662; *Hunt by Hunt* v. *Sherman* (Minn. 1984) 345 N.W.2d 750.) Other decisions have refused to restrict enforcement of a third party liability provisions to the portion of the recovery attributable to medical expenses. (*Foremost Life Ins. Co.* v. *Waters* (1982) 415 Mich. 303 [329 N.W.2d 688]; *Dugan* v. *Nickla* (N.D.Ill. 1991) 763 F.Supp. 981.)

Two decisions, however, have limited the enforcement of third party liability provisions on the ground of public policy. *Westendorf by Westendorf* v. *Stasson* (Minn. 1983) 330 N.W.2d 699, 702, construed a vaguely worded third party liability provision in the light of an applicable Minnesota regulation and concluded that it gave a health maintenance organization the right "only to payments specifically collected by the enrollee for ... medical expenses." In addition, since the provision did not expressly give the health maintenance organization priority to the disputed proceeds, the court relied on the general rule that "absent express contract terms to the contrary, subrogation will not be allowed where the insured's total recovery is less than the insured's actual loss." (*Id.* at p. 703.) *Powell* v. *Blue Cross and Blue Shield* (Ala. 1990) 581 So.2d 772, went a step further. The third party liability provision expressly gave the insurer first priority over proceeds that the beneficiary collected from a third party, specifying: " '... The right to reimbursement ... comes first even if a Member is not paid for all of his claim for damages against the other person ....' " (*Id.* at p. 774, italics omitted.) The court, however, found the provision to be inconsistent with the traditional equitable principle denying a right of subrogation "until the plaintiff/insured has been fully compensated for her loss." (*Id.* at p. 773.) Refusing to "undermine the equitable principles upon which subrogation is based" (*Id.* at p. 775), it held "that the

insurer has no right to subrogation unless and until the insured is made whole for his loss." (*Id.* at p. 777.)

The *Westendorf* decision can clearly be distinguished from the present case. There is no comparable California regulation affecting interpretation of the third party liability provision, and the language of the provision here explicitly gives Health Plan priority to the proceeds of a recovery from a third party. The *Powell* decision is in point but it stands in opposition to a line of authority allowing the insured and insurer to modify by contract the traditional equitable rule conditioning the right of subrogation on the insured's full compensation. (*Peterson* v. *Ohio Farmers Ins. Co.* (1963) 175 Ohio St. 34 [23 Ohio Op.2d 311, 191 N.E.2d 157, 159-160]; *Garrity* v. *Rural Mut. Ins. Co.* (1977) 77 Wis.2d 537 [253 N.W.2d 512, 515-516]; *Hill* v. *State Farm Mut. Auto. Ins. Co.* (Utah 1988) 765 P.2d 864, 868; *Culver* v. *Insurance Co. of North America* (1989) 115 N.J. 451 [559 A.2d 400, 402-404].)

Health Plan also argues that the Department of Corporations, which is entrusted with the regulation of health maintenance organizations, has in effect sanctioned the third party liability provision at issue here. Pursuant to Health and Safety Code section 1352.1, subdivision (a), Health Plan has submitted the original health service Agreement and every subsequent amendment to the department for its review without receiving any objection. Under some unusual circumstances, such repeated administrative review followed by an absence of objection may be entitled to much the same effect as actual approval. (*Bernardini* v. *Home and Automobile Insurance Co.* (1965) 64 Ill.App.2d 465 [212 N.E.2d 499, 501]; *Smith* v. *Motor Club of America Ins. Co.* (1959) 54 N.J.Super. 37 [148 A.2d 37, 41]; *Demmery* v. *National Union Fire Insurance Co.* (1967)

210 Pa.Super. 193 [232 A.2d 21, 24].) In an appropriate case, it may serve to invoke the rule that a regulatory agency's interpretation of a statute it is responsible for enforcing is entitled to "great weight." (*Western Oil & Gas Assn.* v. *Monterey Bay Unified Air Pollution Control Dist.* (1989) 49 Cal.3d 408, 425 [777 P.2d 157].) However, the rule has no application to the present case since the Department of Corporation's nonobjection to the provision cannot be clearly linked to the interpretation of any statute it is charged with enforcing. (See *Armistead* v. *State Personnel Board* (1978) 22 Cal.3d 198, 204-205 [149 Cal.Rptr. 1, 583 P.2d 744]; *Delgado* v. *Heritage Life Ins. Co.* (1984) 157 Cal.App.3d 262, 273 [203 Cal.Rptr. 672]; *Frenzer* v. *Mutual Ben. H. & A. Assn.* (1938) 27 Cal.App.2d 406, 414 [81 P.2d 197].)

Samura's argument based on public policy is similarly inconclusive. (See *Gantt* v. *Sentry Insurance* (1992) 1 Cal.4th 1083, 1095 [4 Cal.Rptr.2d 874, 824 P.2d 680].) Government Code section 985, which authorizes the trial court to reduce the amount of the contractual lien under some circumstances, applies narrowly to judgments against a public entity. Labor Code section 4903.1, subdivisions (a)(2) and (4), gives the appeals board discretionary authority to reduce the amount of liens claimed by health benefit plans against an applicant's settlement recovery but allows unrestricted enforcement of liens against the proceeds of workers' compensation awards. Two other statutes limit the state's lien for recovery of Medi-Cal benefits (Welf. & Inst. Code, § 14124.78) and hospital liens for emergency services (Civ. Code, § 3045.4) to one-half a beneficiary's tort recovery, but these isolated provisions are not enough to evidence a general public policy.

(1b) On balance, our review of applicable law does

not reveal any persuasive support for the rule effected in paragraph 2 of the judgment, that is, a rule limiting enforcement of the third party liability provision "if a member is not adequately compensated by a settlement agreement in third party litigation." But neither does the decisional law offer any consistently persuasive rationale for the third party liability provision; the various reasons offered in justification of the provision are all of limited application and may be entirely absent in some hard cases.

Block v. *Cal. Physicians' Service*, *supra*, 244 Cal.App.2d 266, regards the third party liability provision as serving the goals of cost reduction and avoidance of double recovery: "The clause is ... part of an overall program sanctioned and encouraged by the Legislature ... to provide medical and hospital services on a nonprofit basis at a minimum expense to those participating. [Citation.] ... While [plaintiff] has a right to seek to be made whole, it is unfair for him to seek enrichment by double recovery which would result from retention of all proceeds of the settlement of his suit against Cray and of all medical and hospital benefits paid to him by defendant Service under its agreement—for the same injuries—all eventually at the cost of the participating members of the plan." (*Id.* at p. 273.) But the justification of cost reduction will apply to any exclusion or limitation on insurance coverage, or, for that matter, to elimination of insurance coverage altogether; it has no peculiar force as a rationale for the third party liability provision. Moreover, the possibility of a double recovery—or, in the case of a health maintenance organization, a windfall recovery for medical expenses that the insured did not incur—arises only where the insured recovers the cost of medical expenses from the third party. The third party liability provision is not

limited to this element of recovery, and respondent argues plausibly that various factors, such as underinsurance, compromise, and attorney fees, tend to prevent any actual windfall in most cases.

Language in certain cases suggests another possible rationale for the third party liability provision: the parties may reasonably agree to give the payment of medical costs a higher priority than the recovery of noneconomic damages for pain and suffering. Thus, in *Hartford Accident & Indemnity Co.* v. *Gropman* (1984) 163 Cal.App.3d Supp. 33 [209 Cal.Rptr. 468], the court precluded the defendant from showing the portion of her tort recovery that related to medical bills, "as opposed to other special damages and general damages for pain and suffering." (*Id.* at pp. Supp. 38, 41.) This justification, of course, will apply only when the recovery includes damages for pain and suffering.

Though never clearly articulated, the most important rationale may turn on the concept of fault; it may be thought that the burden of medical expenses should be placed on the wrongdoer. In *Wright* v. *Department of Benefit Payments* (1979) 90 Cal.App.3d 446 [153 Cal.Rptr. 474], where the state sought to recoup the amount of Medi-Cal benefits from a personal injury settlement, the court alluded to the concept of fault in rejecting a due process objection: "Traditional notions of due process and fundamental fairness are not offended by a statutory scheme which permits the public treasury to be reimbursed from Patrick's recovery from the party who caused the injuries for which Medi-Cal paid for the treatment." (*Id.* at p. 451.) This justification assumes that the recovery from the party at fault will create a fund from which medical costs may be paid without burdening the injured party. But where the tort victim does not recover enough from the third

party to compensate for lost wages, future loss of earning capacity, or uninsured future medical expenses, the victim will also bear the burden of paying medical expenses from the tort recovery; in such cases, the third party liability provision may represent a heavy burden on the injured party by reducing recovery of actual economic losses.

In short, the third party liability provision may sometimes operate in a harsh and one-sided manner without any justification, which raises the possible application of the doctrine of unconscionability. As embodied in Civil Code section 1670.5, subdivision (a), the concept of "unconscionability has both a 'procedural' and a 'substantive' element." (*A & M Produce Co.* v. *FMC Corp.* (1982) 135 Cal.App.3d 473, 486 [186 Cal.Rptr. 114, 38 A.L.R.4th 1].) "The former includes (1) 'oppression,' which refers to an inequality of bargaining power resulting in no real negotiation and the absence of meaningful choice; and (2) 'surprise,' which occurs when 'the supposedly agreed-upon terms of the bargain are hidden in a prolix printed form drafted by the party seeking to enforce the disputed terms.' ... [¶] 'Substantive' unconscionability consists of an allocation of risks or costs which is overly harsh or one-sided and is not justified by the circumstances in which the contract was made. [Citation.] Presumably both procedural and substantive unconscionability must be present before a contract will be held unenforceable. However, a relatively larger degree of one will compensate for a relatively smaller degree of the other." (*Dean Witter Reynolds, Inc.* v. *Superior Court* (1989) 211 Cal.App.3d 758, 767-768 [259 Cal.Rptr. 789].)

(1c) In those cases where the third party liability provision has a harsh and one-sided impact, a Health Plan member could unquestionably present a strong

defense to the enforcement of the provision on this ground. The provision is not subject to negotiation (although a prospective member may possibly have the option of shopping for an alternative health plan without the provision). And it represents a departure from the general pattern of the health service agreement that may arguably result in surprise.

We have not found any decision actually adjudicating a third party liability provision as being unenforceable on the ground of unconscionability, but the issue is not in dispute in this appeal. Displaying a commendable candor, Health Plan concedes that judges can "reject applications of subparagraph (e) that shock their conscience." To its credit, it has adopted a policy of waiving the provision in hard cases, despite the absence of precise legal guidelines.

In summary, we have seen that paragraph 2 of the judgment reflects an improper distinction between adequately and inadequately compensated members. The boundaries of legality in the application of the third party liability provision are found rather in the doctrine of unconscionability. Should the judgment be revised to refer instead to the doctrine of unconscionability? The question is linked to another asserted omission in the third party liability provision which is addressed in paragraph 3 of the judgment—reference to the common fund rule. (6) It is well established that, when two or more parties are entitled in common to a fund created by a recovery from a third party, and the costs of litigation have been borne by only one of them, the courts in the exercise of their inherent equitable powers will require the apportionment of costs and attorney fees. (*Lee* v. *State Farm Mut. Auto. Ins. Co.*, *supra*, 57 Cal.App.3d 458, 466-468.) (1d) Thus, the courts will reduce Health Plan's lien

under the third party liability provision by its pro rata share of the member's costs in securing a judgment or settlement from the third party.

In its statement of decision, the trial court based its order in part on the principle, enunciated in *People* v. *McKale*, *supra*, 25 Cal.3d 626, 635, that it is an unfair or fraudulent business practice "to assert a contractual right that one does not have." (Cf. *People* v. *Custom Craft Carpets, Inc.* (1984) 159 Cal.App.3d 676, 683-684 [206 Cal.Rptr. 12].) The third party liability provision at issue asserts an unqualified right to recover the cost of medical services from a member's recovery from a third party. In fact, Health Plan's right of recovery is qualified in two respects—by the doctrine of unconscionability and by the common fund rule. The failure of the third party liability provision to refer to the limitations on Health Plan's right of recovery, the trial court suggests, constitutes a form of unfair competition under Business and Professions Code section 17200.

We do not consider, however, that the present case comes within the *McKale* principle. The defendant mobilehome park in the *McKale* decision included certain unlawful provisions in its rules and regulations which it did not actually attempt to enforce. Despite the lack of enforcement, the court held that the use of the provisions could still be enjoined: "When a mobilehome park operator requires tenants to sign park rules and regulations which the park is prohibited by law from enforcing, those tenants are likely to be deceived, and allegations of unfair competition based thereon are sufficient to withstand demurrer." (25 Cal.3d at p. 635.)

In contrast, the third party liability provision at issue here is entirely lawful on its face but, like many

contract provisions, may be subject to certain defenses and exceptions in application. Health Plan does not try to outline in advance all the factors that may affect application of the provision but rather employs form letters acknowledging these limitations when they arise. Upon learning of a member's claim against a third party, it routinely sends to the member's attorney a letter alluding to its obligation to reduce its claim under the common fund rule. This practice, we find, has no significant tendency to mislead. Again, following recovery by settlement or judgment, it considers whether enforcement of its lien would work a hardship on the member and expresses a willingness to negotiate a reduction of its claim where the possibility of hardship exists. (7)(See fn. 6), (1e) We express no opinion as to whether Health Plan actually avoids problems of unconscionability in this manner—the evidence on this point is conflicting—but we do not consider that it acts unlawfully in negotiating the issue on a case by case basis. In the absence of regulatory guidelines promulgated by the Department of Corporations,[5] the unsettled state of the law and the many potential variables bearing on the issue make it difficult to resolve the problem of unconscionability through a set for-

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5 The matter plainly calls for legislative or regulatory action. As indicated by our analysis, the third party liability provision in practice runs the gamut from essential fairness to unconscionability. Some appropriate formula or guideline might avoid its application, or modify its rigor, in hard cases. Respondent notes ironically "that persons who are Kaiser members through Medi-Cal fare better than persons who pay dues directly." (See Welf. & Inst. Code, § 14124.78.) But despite the desirability of some such limitation, we cannot say that Health Plan acted unlawfully in failing to incorporate a precautionary formula of some kind in the provision.

mula.[6]

We turn now to the question whether the order on appeal was properly based on violations of the Knox-Keene Act. (8) We note preliminarily that Business and Professions Code sections 17203 and 17200 do not confer on Samura a general power to enforce the act. This power has been entrusted exclusively to the Department of Corporations, preempting even the common law powers of the Attorney General. (Health & Saf. Code, §§ 1341 and 1346; *Van de Kamp* v. *Gumbiner* (1990) 221 Cal.App.3d 1260 [270 Cal.Rptr. 907].) Among other things, the Department of Corporations has exclusive power to regulate the provisions of health service agreements of health maintenance organizations and the content of the required disclosure form and evidence of coverage pamphlets. (Health & Saf. Code, §§ 1351 and 1363.)

But, despite the existence of a statutory enforcement scheme, Samura may still sue to enjoin acts which are made unlawful by the Knox-Keene Act. In *People* v. *McKale*, *supra*, 25 Cal.3d 626, the Supreme Court held

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[6] Though the issue has never been adjudicated, a practice of enforcing the third party liability provisions with disregard for considerations of unconscionability might constitute an unfair business practice in violation of the unfairness term of Business and Professions Code section 17200. (*Shadoan* v. *World Savings & Loan Assn.* (1990) 219 Cal.App.3d 97, 101 [268 Cal.Rptr. 207]; *People* v. *Casa Blanca Convalescent Homes, Inc.* (1984) 159 Cal.App.3d 509, 530 [206 Cal.Rptr. 164, 53 A.L.R.4th 661].) But the record here contains no finding of such a practice. We see no other issue relating to the unfairness term of Business and Professions Code section 17200 deserving of extended discussion. The term does not give the courts a general license to review the fairness of contracts but rather has been used to enjoin deceptive or sharp practices. (See *Committee on Children's Television, Inc.* v. *General Foods Corp.* (1983) 35 Cal.3d 197 [197 Cal.Rptr. 783, 673 P.2d 660]; *People* v. *Bestline Products, Inc.* (1976) 61 Cal.App.3d 879, 915 [132 Cal.Rptr. 767].)

that existence of such a distinct enforcement scheme does not preclude a suit to enjoin unfair competition premised on an unlawful practice. The district attorney there sued to enjoin multiple violations of the Mobilehome Parks Act which the Commission on Housing and Community Development was expressly authorized to enforce. The Supreme Court held "that even though a specific statutory enforcement scheme exists a parallel action for unfair competition is proper pursuant to applicable provisions of the Business and Professions Code." (*Id.* at p. 632.) Following McKale, other decisions have upheld use of Business and Professions Code section 17200 to enjoin acts which are declared to be unlawful under a statutory enforcement scheme. (*People* v. *Los Angeles Palm, Inc.* (1981) 121 Cal.App.3d 25, 33-35 [175 Cal.Rptr. 257]; *People* v. *Casa Blanca Convalescent Homes, Inc.*, *supra*, 159 Cal.App.3d 509, 516-520, 531.)

(1f) In its statement of decision, the trial court relied on a number of provisions of the Knox-Keene Act, including Health and Safety Code sections 1342, subdivision (b), section 1360, subdivision (a)(2) and (a)(3), section 1363, subdivisions (a) and (c), and section 1367, subdivision (h). However, only section 1360, subdivision (a)(2) and (a)(3), defines an unlawful act that may be enjoined as unfair competition under the Business and Professions Code; the other statutes pertain to the exercise of the Department of Corporation's regulatory power.

Health and Safety Code section 1360, subdivision (a) broadly prohibits deceptive practices in advertising or soliciting participation in a health care service plan: "No plan, solicitor, solicitor firm, or representative shall use or permit the use of any advertising or solicitation which is untrue or misleading, or any form of evidence

of coverage which is deceptive." Subdivision (a)(2) and (a)(3) provide that a statement may be deemed misleading or deceptive even if it is literally true.[7]

We note that by its terms Health and Safety Code section 1360 has little relevance to the matters enjoined in the judgment. The statute does not apply to communications between Health Plan and its members; it therefore has no application to paragraphs 5, 6, 7 or 9 of the court's order. Moreover, we construe the statute as applying only to the deceptive "use" of documents in advertising or solicitation. Documents that are not actually used for this purpose will not come within the terms of the statute, even though they come within the definition evidence of coverage under Business and Professions Code section 1345. Thus, since there is no evidence that the health care service contract here was actually used in acquainting the public with the terms of the plan, we have no need to consider whether the contract complies with the statutory standards of section 1360.

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7 "... For purposes of this article: [¶] (2) A written or printed statement or item of information shall be deemed misleading whether or not it may be literally true, if, in the total context in which the statement is made or such item of information is communicated, such statement or item of information may be understood by a person not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage, or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee, or potential enrollee or subscriber, in a plan, and such is not the case. [¶] (3) An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge of plans, and evidence of coverage therefor to expect benefits, service charges, or other advantages which the evidence of coverage does not provide or which the plan issuing such coverage or evidence of coverage does not regularly make available to enrollees or subscribers covered under such evidence of coverage."

Under our interpretation, Health and Safety Code section 1360 applies only to paragraph 4 of the judgment—a rather trivial provision enjoining Health Plan "from calling the [third party liability] term a 'reduction.' " We find nothing misleading or deceptive in the use of this term. The Knox-Keene Act has three classifications of provisions limiting coverage: exceptions, reductions and limitations. (Health & Saf. Code, § 1362.) Since the third party liability provision ordinarily requires partial payment for a health care service provided to a member, it best fits the definition of a reduction in benefits. (Health & Saf. Code, § 1362, subd. (c); Cal. Code Regs., tit. 10, § 1300.67.4, subd. (a)(3).)

The other statutory provisions cited in the statement of decision serve to govern the Department of Corporations in the exercise of its regulatory powers. Health and Safety Code section 1342 contains a statement of legislative purpose; section 1363 regulates the content of the disclosure form provided to prospective members; and section 1367 sets forth certain requirements for health care service plans and requires service agreements to be "fair, reasonable, and consistent with the objectives of this chapter." In relying on these provisions, the court improperly sought to enforce compliance with the regulatory guidelines and requirements of the Knox-Keene Act. Thus, paragraph 1 requires that the third party liability term be written "in plain English" and be given "greater prominence"; paragraphs 5, 6 and 7 concern statements in the medical payment order sent to members subject to the third party liability provision; paragraph 8 concerns representations that the third party liability term "excludes or reduces" coverage; and paragraph 9 concerns content of standard form letters.

It is immaterial whether or not the challenged contract provisions and business practices comply with these portions of the Knox-Keene Act because the statutes do not define unlawful acts that may be enjoined under Business and Professions Code section 17200.[8] In basing its order on these provisions, the trial court assumed a regulatory power over Health Plan that the Legislature has entrusted exclusively to the Department of Corporations. Samura unquestionably has certain remedies if the Department of Corporations fails to discharge its responsibilities under the Knox-Keene Act (see Health & Saf. Code, § 1397), but the courts cannot assume general regulatory powers over health maintenance organizations through the guise of enforcing Business and Professions Code section 17200. (Cf. *Rubin* v. *Green* (1993) 4 Cal.4th 1187, 1201 1202 [17 Cal.Rptr.2d 828, 847 P.2d 1044].) To the extent that the order on appeal is based on portions of the Knox-Keene Act having a purely regulatory import, it improperly invades the powers that the Legislature entrusted to the Department of Corporations.

(9) In a separate appeal, Samura claims that the trial court erred in refusing to enjoin enforcement of the third party liability provision in any form. It raises only one issue not covered in the preceding analysis—the applicability of the federal Health Maintenance Organization Act of 1973 (42 U.S.C. §300e et seq.). The federal statute provides certain forms of financial assistance and other benefits to qualifying health maintenance organizations. Samura points out that the act specifically authorizes a health maintenance organi-

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[8] Our observation extends to the many other provisions of the Knox-Keene Act cited in Samura's brief.

zation to seek reimbursement from workers' compensation benefits (42 U.S.C. 300e(b)(1)(D)), and argues that this narrow authorization implies that federally qualified health maintenance organizations are prohibited from adopting broader provisions providing for reimbursement from third parties. We find it unnecessary to enter into the complicated legislative and regulatory history in point. Whatever may be the impact of the provision on Health Plan's status under the Health Maintenance Organization Act, we find nothing in the statute or related regulations that declares a third party liability provision to be unlawful as a matter of substantive law. Hence, assuming without deciding that Business and Professions Code section 17200 can be employed to enjoin violations of federal law, Samura cannot predicate a cause of action under section 17200 on violation of the federal Act. (Cf. *People ex rel. Dept. of Transportation* v. *Naegele Outdoor Advertising Co.* (1985) 38 Cal.3d 509, 523 [213 Cal.Rptr. 247, 698 P.2d 150]; *Diaz* v. *Kay-Dix Ranch* (1970) 9 Cal.App.3d 588 [88 Cal.Rptr. 443].)

Since the trial court's order must be reversed, we do not reach the question whether Samura's cause of action is preempted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1001 et seq.) to the extent that it applies to group plans of employers and unions.

The judgment is reversed.[9] Costs to Health Plan. Strankman, P. J., and Stein, J., concurred.

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[9] Our reversal of the judgment also entails reversal of the lower court's order awarding attorney fees with respect to which Health Plan has filed a separate notice of appeal.

2. *Samura v. Kaiser Foundation Health Plan, Inc., et al.*,
Superior Court for the State of California, County of Alameda, No. 605676-4.

Statement of Decision, Oct. 10, 1991.

A central feature of an HMO is that its members are not charged fees based on the extent of medical care which they receive but instead are charged a periodic pre-set membership fee which pays for basic health care. (H&S Code § 1340, et seq; 42 U.S.C. §300e.) Kaiser's[1] TPL term is inconsistent with this central feature. Under the TPL term, Kaiser charges its members fees-for-services based on the frequency, time and cost of health care. A TPL bill can be greater than the total recovery. (Emerson) Some members of the public would select other health care coverage in order to avoid the TPL term. (Samura) Because of the nature and effect of the TPL term, it must be prominently disclosed and explained in plain, everyday English in order to reveal that members must share any recovery with Kaiser and to permit the public to make informed choices. (H&S §§ 1342(b), 1360(a)(2), (a)(3), 1363(a), 1374.22(b); see *Lee* v. *State Farm Mut. Auto Ins. Co.* (1976) 57 Cal.App.3d 458.

However, Kaiser leads the public to expect that it charges only the membership dues and nominal supplemental payments for health care services. The form

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1 "Kaiser" hereafter refers defendants collectively: They present themselves and operate with regard to the TPL term in a manner that causes the public to consider them as a single entity. Each defendant is jointly and severally liable.

and content of Kaiser's writings do not disclose in a clear and prominent manner that members are charged prevailing rates, i.e., "Non-Member Rates," as though the person was not a Kaiser member for each of the services (in addition to full membership dues) if the member collects anything from a third party. Kaiser receives many calls from members who are surprised to learn of the existence of the TPL term or who are confused about its meaning. (Emerson)

In various writings, the TPL term is titled "Reduction." The title is misleading. (H&S § 1363(c).) The TPL term does not (and an HMO cannot) reduce the extent of medical services available to the member, it changes the amount which the member must pay for benefits if the member recovers from a third party. The term is sub-titled "Emergency Services Received at Kaiser Foundation Hospitals" even though it applies to all types of health care and not only to emergency care. The TPL term erroneously states that services are provided in exchange for Non-Member Rates when, in fact, services are provided because membership dues were timely paid; the TPL term imposes a surcharge for services which is computed using Non-Member Rates). In addition, Kaiser's materials assert that the TPL term "excludes" coverage of services delivered to members injured by third parties if the member recovers from the third party which is false and misleading.

HMO documents must be intelligible to a "reasonable person, not possessing special knowledge of plans". (H&S § 1360 (a)(3).) Kaiser must rewrite the TPL term in plain English, purge any indication that the TPL term "reduces" or "excludes" coverage from every description or summary of the term and place the TPL term where it is likely to be read and understood by its members. (H&S § 1360; *Lee* v. *State Farm, supra*, at

pp. 469-471.)

A TPL term is not unfair if the member is fully compensated and the term is applied to preclude the member from receiving a windfall. (*Block* v. *Cal. Physicians' Service* (1966) 244 Cal.App.2d 266, 273.) However, it is unfair to the member to use the TPL term to take an inequitable portion of the member's under-recovery. (*Lee* v. *State Farm, supra*, 57 Cal.App.3d 458; see also, *Westendorf by Westendorf* v. *Stasson* (Minn. 1983) 330 N.W.2d 699, 703.) Kaiser sometimes discounts the amount of its TPL claim if it is convinced that a member was substantially undercompensated, but members are not consistently informed that they may seek a discount because they were not fully compensated. (Emerson.) At the same time, Kaiser claims the contractual prerogative to take 100% of a member's recovery even if the member was grossly undercompensated. It is an unfair trade practice to assert a contractual right that one does not have. (*Peo.* v. *McKale* (1979) 25 Cal.3d 626.)

Kaiser's terms must be fair to its members, and the terms must shift the risks of the cost of basic health care to Kaiser. (H&S §1367(h).) It is unfair to require a Kaiser member to pay for basic health care on a fee-for-service basis for all care simply because the member has received some money from a tortfeasor. Kaiser does not assume the risk of providing basic health care if it claims more than a pro rata share of a recovery.[2]

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[2] Also, Kaiser must discount TPL claims when members are undercompensated to avoid a windfall *to Kaiser* at the expense of the member. The TPL claims are based on Non-Member Rates. Kaiser does not calculate its costs. The rates may exceed Kaiser's costs and when they do, Kaiser receives a windfall at its members' expense. Ultimately, the requirement that HMO contracts shift the financial cost of health

Kaiser must reduce its TPL claim proportionately when a recovery does not fully compensate a member; also, this must be standardized and adequately disclosed. Kaiser must pay a pro rata share of the attorneys fees and costs incurred in creating the fund from which the TPL claim is paid. (*Lee* v. *State Farm, supra*, at pp. 468-469.) Kaiser's contribution to fees and costs is essential for the TPL term to be fair and for the agreement to retain its risk-shifting character. Kaiser does not disclose in a consistent manner its obligation and practice to discount the TPL claim on request, and it contributes its share only when requested to do so. (Emerson.) The TPL term and other documents sent to members must disclose that Kaiser will contribute to fees and costs.

When Kaiser suspects a TPL event, Kaiser sends the member an MPO requesting the member promise to pay Kaiser's full TPL claim from any subsequent recovery without a discount for fees, costs or under-recovery. (PX-52; Emerson.) Kaiser's MPO must explain that a fair discount of the TPL claim will be made for fees, costs or hardship.

Kaiser is not an ERISA plan although Kaiser membership may be offered as a plan benefit by funded ERISA plans. (*Hewlett-Packard Co.* v. *Barnes* (9th 1978) 571 F.2d 502, 504.) Kaiser is equivalent to an insurer for purposes of ERISA. (*Manasen* v. *Cal. Dent. Serv.* (1976) 424 F.Supp. 657.) ERISA does not preempt state laws regulating insurance. The Knox-Keene Act and decisional law governing reimbursement provisions of insurance contracts constitute laws regulat-

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care to the HMO requires that Kaiser discount its TPL claim even if the result is that Kaiser collects less than its costs.

ing insurance within the meaning of ERISA. (*Ibid.*, *FMC Corp.* v. *Holliday* (1990) ___ U.S. ___ (12 EBC 2689); *United Food* v. *Pacyga* (9th 1986) 801 F.2d 1157.) Plaintiff's section 17200 claims based on these insurance laws are saved from ERISA preemption because Kaiser is not a self-funded ERISA plan. A section 17200 claim standing alone does not relate to ERISA. State laws requiring Kaiser's advertising materials to be truthful and accurate do not "relate" to ERISA. (*Fort Hallifax* v. *Coyne* (1987) 482 U.S. 1.) This case does not involve the issue of benefits due under an ERISA plan, it involves whether an HMO doing business in California with ERISA plans must conform its business practices with the state's laws regulating HMOs. ERISA does not preempt plaintiff's claims.

The HMO Act does not expressly authorize or prohibit TPL terms. (42 U.S.C. 300e (b)(1).) The regulations enacted to implement the HMO Act do not expressly authorize or prohibit TPL terms. HHS (which is charged with implementing the HMO Act) has never disapproved a contract containing a TPL term. The TPL term does not violate the HMO Act.

Plaintiff stipulated that this complaint does not reach contracts between Kaiser and members of federal employee groups.[3] Also, plaintiff did not challenge Kaiser's practice of seeking reimbursement of payments made to other hospitals that had provided emergency care to Kaiser members (sometimes called "out of plan benefits"). This court did not consider any aspect of that practice.

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[3] However, while this Court lacks jurisdiction to compel Kaiser to make the TPL term clear and prominent for federal employees, the benefit from rewriting the term need not be denied to them merely because of their status.

The court reserves jurisdiction over this action to implement the terms of the judgment.

Dated: 10/10/91

Hon. Dawn Girard, Judge,
Alameda County Superior Court

3. *Samura v. Kaiser Foundation Health Plan, Inc., et al.*,
Superior Court for the State of California, County of Alameda, No. 605676-4.

Judgment, Oct. 10, 1991.

JUDGMENT AFTER TRIAL BY COURT

This action come on regularly for trial on March 4, 1991. Plaintiff appeared through his attorney, Law Office of Manuel Glenn Abascal, by Manuel Abascal and Kathy Shull Abascal, and defendants Kaiser Foundation Health Plan, Inc., The Permanente Medical Group, Inc. and Kaiser Foundation Hospitals, (hereafter collectively "Kaiser"), appeared through their joint attorney, Law Office of Kennedy P. Richardson, by Kennedy P. Richardson. A jury trial having been waived, the court having heard and considered the pleadings and all documents filed relating to this action, the testimony of witnesses and exhibits admitted, and the argument of counsel, the matter having been submitted for decision and the court having issued its statement of decision, the court orders, adjudges and decrees that:

Judgment be and is hereby entered in favor of plaintiff and against defendants and each of them on Count One and Count Two of the First Amended Complaint granting injunctive relief, costs of suit and attorney's fees.

The Northern California Region of the Kaiser Foundation Health Plan, Inc., The Permanente Medical Group, Inc. and Kaiser Foundation Hospitals, and each of them, are enjoined to clarify and explain the

TPL terms in its agreements as follows:

1. Rewrite the TPL term in plain English and give greater prominence to the term in the contract.

2. Include a provision in the contract that standardizes and clarifies the method of reducing the amount of its claim if a member is not adequately compensated by a settlement agreement in third party litigation and include a provision in the TPL term for determining whether or not a member is adequately compensated.

3. Provide in the contract that Kaiser will share pro rata in the costs of litigation and attorney fees.

4. Refrain from calling the TPL term a "reduction."

5. Inform members in the medical payment order that Kaiser will share pro rata in litigation costs and in attorney fees.

6. Inform members in the medical payment order that Kaiser may reduce the amount of its claim if the member is not adequately compensated.

7. Refrain from combining the medical payment order with a medical information release authorization form.

8. Refrain from including any representations that the TPL term excludes or reduces coverage in the contract or standard form letters to members and/or their attorneys.

9. Standardize form letters regarding the TPL term to ensure that all members are informed of Kaiser's practice of reducing its claim to share pro rata in costs of litigation and attorney fees.

Kaiser is ordered to report in writing to the court within sixty (60) days of the filing of this judgment in

the Superior Court. The report shall fully describe all actions and policies undertaken, approved or adopted or announced toward the end of implementing this order, judgment and decree. Said report shall be filed in this action and served on counsel for plaintiff. The court or either of the parties may notice a hearing on the matters in the report. As used herein, "actions" shall mean: (1) the actual steps which Kaiser contends demonstrates compliance, or progress toward compliance, with the matters ordered to be changed by this order, judgment and decree.

The Court retains jurisdiction to enforce compliance with this order, judgment and decree and to modify the terms of this judgment from time to time as appear just to ensure such compliance as well as to evaluate Kaiser's progress in achieving and maintaining compliance. The Court's jurisdiction to enforce compliance shall expire three years after the judgment is final or sooner, upon order of the court.

The Court reserves jurisdiction to consider a timely filed application by plaintiff for attorney fees.

DATED: 10/10/91

Honorable Dawn Girard, Judge
Alameda County Superior Court

4. *SAMURA v. KAISER FOUNDATION HEALTH PLAN, INC.* 715 F. Supp. 970 (N.D.Cal. 1989)

ARTHUR BRADLEY SAMURA, Plaintiff,
v.
KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.

No. C-89-1413-WWS
United States District Court
N.D. California
July 18, 1989

Manuel Glenn Abascal, Kathy S. Abascal, Berkeley, Cal., Stephen Kaus, Kaus, Kerr & Wagstaffe, San Francisco, Cal., for plaintiff.

Kennedy P. Richardson, Oakland, Cal., for defendants.

ORDER

SCHWARZER, District Judge

Plaintiff has moved pursuant to 28 U.S.C. section 1447(c) to remand this action to the Superior Court of the State of California, County of Alameda, from which it was removed, on the ground that the removal was improvident and untimely. Plaintiff also requests costs and attorney fees incurred in making the motion.

I. FACTS

Plaintiff filed a class action on November 20, 1985, in Alameda County Superior Court against Kai-

ser Foundation Health Plan, Inc. ("Health Plan"), alleging that Health Plan's practice of asserting liens in excess of provider costs on recoveries obtained from third parties constitutes an unfair business practice in violation of the California Unfair Practices Act, Cal. Bus. & Prof. Code, §§ 17200, *et seq.* On October 27, 1987, Health Plan filed a first amended answer to the complaint asserting as an affirmative defense that the complaint "is barred and preempted by section 514(a) of the federal Employee Retirement Security Act of 1974, 29 U.S.C. § 1144(a)."

On April 10, 1989, plaintiff filed a first amended complaint adding Permanente Medical Group and Kaiser Foundation Hospitals, Inc. as defendants. The first amended complaint for the first time alleged that defendants are a federal qualified Health Maintenance Organization under 42 U.S.C. sections 300e, *et seq.*, and that their practice of collecting more than prepaid dues from its members is a violation of section 300e and therefore a violation of the Unfair Practices Act.

On April 25, 1989, more than thirty days after service of the original complaint, defendants removed the action to this court. The petition for removal invoked federal question jurisdiction under 28 U.S.C. § 1331 on two grounds:

1. that plaintiff has stated a claim under 42 U.S.C. § 300e, and

2. that all of the allegations of the complaint relate to an employee benefit plan and are therefore preempted by section 514 of ERISA, 29 U.S.C. § 1144.

[1] Plaintiff has moved to remand on the ground that the action was not timely removed.[1]

II. DISCUSSION

A. Addition of New Defendants

[2] Defendants contend that removal was timely because it came within thirty days of service of the amended complaint which added two new defendants. The addition of defendants, however, does not start the time for removal running anew when the original complaint was removable. The decision in *Cantrell v. Great Republic Insurance Company*, 873 F.2d 1249 (9th Cir. 1989), is squarely in point.

The result in *Cantrell* did not turn on the later named defendant's close association with the litigation but, even if it did, the instant defendants are plainly in a similar position, having the same counsel, having filed a joint answer and being part of a group of closely affiliated entities.

It is noteworthy, too, that the *Cantrell* complaint also had been filed in 1985 and was removed two years later on the ground of ERISA preemption.

In view of *Cantrell*, there is no need to discuss the prior state of the law. It should be noted, however, that the decision on which defendants place principal reliance, *Garside v. Osco Drug, Inc.*, 702 F. Supp. 19 (D.Mass. 1988), makes it clear that the published opinions have rejected the view advanced by defendants here. And *Garside*, of course, was a reverse

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[1] Plaintiff also raises defendants' failure to comply with the procedural requirement of 28 U.S.C. § 1446(a), as amended in 1988 by Pub. L. 100-702, Title X, § 1016(b). Defendants' filing of a verified petition for removal rather than a notice of removal reflects their inattention to the applicable law but is not a "defect" warranting remand under section 1447(c).

remand case where the removing defendant sought remand for the purpose of judge-shopping.

B. Addition of a New Federal Cause of Action

[3] Defendants also contend that the addition of a claim under the federal HMO act restarts the period of removal. The simple answer to this contention is contained in the removal statute itself which provides in pertinent part:

> If the case stated by the initial pleading is not removable, a notice of removal may be filed within thirty (30) days after receipt by the defendant through service or otherwise, of a copy of an amended pleading, motion, order or other paper from which it may first be ascertained that the case is one which is or has become removable,....

28 U.S.C. § 1446(b) (emphasis added).

Changes to a complaint that create a new basis for removal do not undo the original waiver. "If a case is removable from the outset, it must be removed within the initial thirty-day period specified by § 1446(b); subsequent events do not make it 'more removable' or 'again removable'." *Hubbard v. Union Oil Company*, 601 F. Supp. 790, 795 (S.D.W.Va. 1985).

"The courts have read into the statute an exception for the case where the plaintiff files an amended complaint that so changes the nature of [the] action as to constitute 'substantially a new suit begun that day.'" *Wilson v. Intercollegiate (Big Ten) Conference Athletic Association*, 668 F.2d 962, 965 (7th Cir. 1982) (quoting *Fletcher v. Hamlet*, 116 U.S. 408, 410, 6 S.Ct. 426, 429, 29 L.Ed. 679 (1886)). The *Wilson* court went on to explicate the relevant policy considerations governing the application of this exception:

The purpose of the 30-day limitation is twofold: to deprive the defendant of the undeserved tactical advantage that he would have if he could wait and see how he was faring in state court before deciding whether to remove the case to another court system; and to prevent the delay and waste of resources involved in starting a case over in a second court after significant proceedings, extending over months or even years, may have taken place in the first court. These considerations might be overborne in a case where a plaintiff, seeking to mislead the defendant about the true nature of his suit and thereby dissuade him from removing it, included in his initial complaint filed in a state court an inconsequential but removable federal count unlikely to induce removal and then, after the time for removal had passed without action by the defendant, amended the complaint to add the true and weighty federal grounds that he had been holding back. ... But this case presents the opposite pattern. Wilson tendered his fundamental federal claim, that defendants had violated his equal protection and due process rights under the U. S. Constitution, at the very outset. His amended complaint added one purely procedural count which clearly did not alter the character of the suit . . . and a number of other federal counts, all apparently makeweights and some never pressed at all. It seems inconceivable to us (and defendants do not argue) that Wilson's lawyer adopted this pleading sequence in order to discourage the defendants from ex-

ercising their right to removal, or that it could have had that effect.

668 F.2d at 965.

This case falls into the same pattern. The amended complaint did not change the nature of the underlying claim. The reference to the federal HMO act merely provides an added standard governing application of the Unfair Practices Act.

Defendants should never have filed a petition for removal in 1989. Their arguments are makeweights at best, presumably intended to cure their earlier neglect to move in a timely fashion. They should have known that their tenuous contentions could not overcome the firmly established policy that "removal statutes are construed strictly against removal." *Libhart v. Santa Monica Dairy Co.*, 592 F.2d 1062, 1064 (9th Cir. 1979).

Counsel for plaintiff are directed to submit proof of attorney fees and expenses, which will be awarded pursuant to 28 U.S.C. § 1447(c), along with a proposed order awarding fees and expenses and remanding the action.

IT IS SO ORDERED.

5. *Samura v. Kaiser Foundation Health Plan, Inc., et al.,*
California Supreme Court, No. S035199

First Appellate District, Division One,
No. A055730/A057515

S035199

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

IN BANK

ARTHUR BRADLEY SAMURA, Appellant

v.

KAISER FOUNDATION HEALTH PLAN INCORPORATED Et Al., Appellants
And Companion Case

Petition for review DENIED.

Kennard, J. and Arabian, J. are of the opinion the petition should be granted.

The requests for an order directing depublication of the opinion are denied.

Lucas,
Chief Justice

6. THE HEALTH MAINTENANCE ORGANIZATION ACT, 42 U.S.C. § 300e (a) & (b) (1) (1993).

§ 300e. Requirements of health maintenance organizations

(a) "Health maintenance organization" defined. For purposes of this title, the term "health maintenance organization" means a public or private entity which is organized under the laws of any State and which (1) provides basic and supplemental health services to its members in the manner prescribed by subsection (b), and (2) is organized and operated in the manner prescribed by subsection (c).

(b) Manner of supplying basic and supplemental health services to members. A health maintenance organization shall provide, without limitations as to time or cost other than those prescribed by or under this title, basic and supplemental health services to its members in the following manner:

(1) Each member is to be provided basic health services for a basic health services payment which (A) is to be paid on a periodic basis without regard to the dates health services (within the basic health services) are provided; (B) is fixed without regard to the frequency, extent, or kind of health service (within the basic health services) actually furnished; (C) except in the case of basic health services provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education, is fixed under a community rating system; and (D) may be supplemented by additional nominal payments which may be required for the provision of specific services (within the basic health services), except that such payments may not be required where or in such a

manner that they serve (as determined under regulations of the Secretary) as a barrier to the delivery of health services. Such additional nominal payments shall be fixed in accordance with the regulations of the Secretary. If a health maintenance organization offers to its members the opportunity to obtain basic health services through a physician not described in subsection (b)(3)(A), the organization may require, in addition to payments described in clause (D) of this paragraph, a reasonable deductible to be paid by a member when obtaining a basic health service from such a physician. A health maintenance organization may include a health service, defined as a supplemental health service by section 1302(2) [42 USCS §300e-1(2)], in the basic health services provided its members for a basic health services payment described in the first sentence. In the case of an entity which before it became a qualified health maintenance organization (within the meaning of section 1310(d) [42 USCS § 300e-9(d)]) provided comprehensive health services on a prepaid basis, the requirement of clause (C) shall not apply to such entity until the expiration of the forty-eight month period beginning with the month following the month in which the entity became such a qualified health organization. The requirements of this paragraph respecting the basic health services payment shall not apply to the provision of basic health services to a member for an illness or injury for which the member is entitled to benefits under a workmen's compensation law or an insurance policy but only to the extent such benefits apply to such services. For the provision of such services for an illness or injury for which a member is entitled to benefits under such a law, the health maintenance organization may, if authorized by such law, charge or authorize the provider of such services

to charge, in accordance with the charges allowed under such law, the insurance carrier, employer, or other entity which under such law is to pay for the provision of such services or, to the extent that such member has been paid under such law for such services, such member. For the provision of such services for an illness or injury for which a member is entitled to benefits under an insurance policy, a health maintenance organization may charge or authorize the provider of such services to charge the insurance carrier under such policy or, to the extent that such member has been paid under such policy for such services, such member.

7. Kaiser Foundation Health Plan, Inc., Third Party Liability term.

The 1991 TPL term provided as follows:

"**Reductions.** The benefits of Members are subject to the following Reductions:

(1) **Injuries or Illnesses Caused or Alleged to be Caused by Third Parties.** Members are required to pay for services as follows:

(a) **Emergency Services Received at Kaiser Foundation Hospitals**. If an injury or illness is caused or alleged to be caused by any act or omission of a third party, services and other benefits are furnished or arranged by Physicians and Hospitals at Non-Member Rates. Payment of these charges is the Member's responsibility, except that the Member is not required to pay any portion of such charges for services and other benefits which is in excess of the total amount that the Member, (or his or her estate, parent or legal guardian) received from or on behalf of the third party on account of such acts or omissions, whether by settlement or judgment. Payment shall be made from the proceeds of the settlement or judgment, and Health Plan (or its designee) shall have a lien on the settlement or judgment for that purpose. At Health Plan's (or its designee's) request the Member (or his or her estate, parent or legal guardian) shall execute a lien form(s) directing his or her attorney or the third party to make payments to Health Plan (or its designee). In the event that Health Plan is required to institute legal action to enforce its lien, the Member shall reimburse Health Plan for the reasonable costs of collection, including attorney's fees.

(b) Emergency Services Received at Facilities Other than Kaiser Foundation Hospitals. If any injury or illness is caused or alleged to be caused by any act or omission of a third party, payments under Section S of the benefit Schedule(s) are made for the services of non-Medical Group Physicians, any hospitals other than Kaiser Foundation Hospitals, and other providers not contracting with Health Plan however, the Member must reimburse Health Plan for any amounts paid by Health Plan up to the total amount that the Member, (or his or her estate, parent or legal guardian) receives from or on behalf of the third party on account of such acts or omissions, whether by settlement or judgment. Reimbursement is the Member's responsibility and shall be made from the proceeds of the settlement or judgment, and Health Plan shall have a lien on the settlement or judgment for that purpose. At Health Plan's request the Member (or his or her estate, parent or legal guardian) shall execute a lien form(s) directing his or her attorney or the third party to make payments directly to Health Plan (or to its designee). In the event that Health Plan is required to institute legal action to enforce its lien, the Member shall reimburse Health Plan for the reasonable costs of collection, including attorney's fees.

The Member further agrees that he or she (or his or her estate, parent or legal guardian) will notify Health Plan of any actual or potential claim or legal action which the Member anticipates bringing or has brought against any third party arising from the alleged acts or omissions not later than 30 days subsequent to submitting or filing a claim or legal action against the third party.

(c) Medicare Member Covered by Motor Vehicle Insurance Policy. When hospital has provided services to a Medicare Member or Part A Member for an injury or illness described in subsection 1(a) or 1(b) above, Hospitals will, in compliance with federal law, seek reimbursement under the medical expense payment provisions of any motor vehicle insurance policy covering the Member. Each such Member must furnish information about the existence and terms of such policy, and complete and submit all claims, releases and other documents necessary for Hospitals to comply with federal law.

(d) Subrogation Agreement. At Health Plan's request, a member (or his or her estate, parent or legal guardian) shall executive [sic] a written subrogation agreement which subrogates Health Plan (or its designee) to all claims, causes of action, and other rights which the Member (or his or her estate, parent or legal guardian) may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation or indemnification on account of the injury or illness allegedly caused by the third party. Under this subrogation agreement, Health Plan (or its designee) shall be subrogated to such claims, causes of action, and rights only to the extent of the total payment and reimbursement to which Health Plan (or its designee) would otherwise be entitled under subparagraphs (a) and (b) above. The subrogation agreement shall grant Health Plan (or its designee) a lien on any judgment or settlement which the Member (or his or her estate, parent or legal guardian) may obtain against a third party."

(e) Priority of Health Plan's Claim. Health Plan (or its designee) shall be entitled to the payment, reimbursement, and subrogation as provided in this Section C(1) regardless of whether the total amount of the recovery is less than the actual loss suffered by the Member (or his or her estate, parent or legal guardian) on account of the injury or illness is less than the actual loss suffered by the member (or his or her estate, parent or legal guardian). The proceeds of any judgment or settlement obtained by Health Plan (or its designee) or the Member (or his or her estate, parent or legal guardian) on account of the injury or illness shall first be applied to satisfy Health Plan's (or its designee's) claims, liens, and other rights under this Section C(1).

(2) Medicare. Benefits are reduced by any benefits to which a Member is entitled under Medicare.

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No. 93-1502

In The

Supreme Court of the United States

October Term, 1993

ARTHUR BRADLEY SAMURA,

Petitioner,

vs.

KAISER FOUNDATION HEALTH PLAN, INC., THE PERMANENTE MEDICAL GROUP, INC. and KAISER FOUNDATION HOSPITALS, INC.,

Respondents.

On Petition for Writ of Certiorari to the California Court of Appeal, First Appellate District, Division One

RESPONDENTS' BRIEF IN OPPOSITION

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13 pp

COUNTER STATEMENT OF QUESTION PRESENTED FOR REVIEW

Must a *state* court construe a *state* statute that affords equitable remedies against unlawful business practices as prohibiting a health maintenance organization's contract provision if the provision is *impliedly* inconsistent with the federal Health Maintenance Organization Act?

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Statutes Cited:

Knox-Keene Health Care Service Plan Act of 1975, §§ 1340, *et seq.* 1, 2, 3, 6

California's Business and Professions Code, § 17200 ....*passim*

Health Maintenance Organization Act, 452 U.S.C. §§ 300e(b)(1), *et seq.* .....*passim*

Respondents Kaiser Foundation Health Plan, Inc., The Permanente Medical Group, Inc. and Kaiser Foundation Hospitals respectfully request that this Court deny the petition for writ of certiorari submitted by Arthur Bradley Samura seeking review of a decision by the California Court of Appeal, First Appellate District, Division One.

STATEMENT OF THE CASE

Respondent Kaiser Foundation Health Plan, Inc. (Health Plan) is a non-profit California health maintenance organization (HMO) licensed under California's Knox-Keene Health Care Service Plan Act of 1975, §§ 1340, *et seq.*, Health and Safety Code (Knox-Keene Act). This act comprehensively regulates the business and contracts of HMOs in California and is administrated by the California Department of Corporations. Health Plan contracts with respondents The Permanente Medical Group, Inc. (Medical Group) and Kaiser Foundation Hospitals (Hospitals) to provide medical and hospital services to its members. The terms and conditions of a member's health care coverage are set forth in a medical and hospital service agreement (service agreement) entered into between Health Plan and the member, or the member's employer, union or other sponsoring organization.

The service agreements contain certain standard limiting conditions, including the third party liability (TPL) provision. The TPL provision provides that if a member is treated by Medical Group or Hospitals for an injury or illness caused by a third party and thereafter recovers compensation for the injury, Health Plan may recoup the value of the health care services. Health Plan is entitled to a first priority lien on the recovered amount up to the value of the services. This value is determined on the basis of the fee schedule which applies to medical care rendered by Medical Group and Hospitals to patients who are not Health Plan members.

Petitioner Arthur Samura was injured in an automobile accident, and his injury was treated by Medical Group under the service agreement. Petitioner then sued and obtained a recovery from the third party tortfeasor. Health Plan initially requested payment under the TPL provision, then waived its claim according to its customary practice of reducing or waiving its TPL claims when a member's economic losses are disproportionately high in relation to the member's settlement recovery.

Petitioner sued Health Plan, Medical Group, and Hospitals, claiming that the TPL provision and Health Plan's administration of it violated § 17200 of California's Business and Professions Code. Section 17200 provides injunctive relief for unfair, deceptive, or unlawful business practices. Petitioner alleged that the TPL provision was unfair and deceptive. He also alleged that it was unlawful. The claim of unlawfulness purported to arise from a number of statutory and judicial sources, the principal one being the Knox-Keene Act. Petitioner included among these sources of unlawfulness the federal Health Maintenance Organization Act, 42 U.S.C. §§ 300e(b)(1), *et seq.* (HMO Act), which he claimed prohibited TPL provisions.

Contrary to petitioner's suggestion (Pet., p. ii), Health Plan, Medical Group, and Hospitals were the only entities involved in the case below. Contracts between affiliated Kaiser HMOs outside Northern California and their members have no connection to the lawsuit below. The suit below challenged only the TPL provision and practices of Health Plan's Northern California Region. It sought only to enforce California's Unfair Business Practices Act, a statute that has no effect on the practices of health care entities in states other than California.

Following a trial, the California Superior Court for the County of Alameda found that some aspects of the TPL provision violated various sections of the Knox-Keene Act and were therefore

enjoinable as an unlawful business practice under § 17200. The trial court ordered that Health Plan revise the provision and some of the implementing documents. The court also found, however, that the HMO Act did not expressly authorize or prohibit the TPL provision.

The evidence regarding petitioner's HMO Act theory consisted mostly of testimony from a former official of the division of the United States Department of Health, Education and Welfare (HEW), the predecessor of the Department of Health and Human Services (HHS), which regulated federally qualified HMOs under the HMO Act. This witness testified that it has been the consistent practice of HEW and HHS to approve of TPL provisions in the service agreements of federally qualified HMOs. Indeed, petitioner stipulated that neither HEW nor HHS has ever objected to a TPL provision in a federally qualified HMO's service agreement.

Health Plan appealed the order and petitioner cross-appealed. The California Court of Appeal for the First District, on August 17, 1993, issued the opinion that is the subject of the present petition. The Court of Appeal reversed the trial court's order in all respects, except that pertaining to the HMO Act. The court held that the TPL provision was not unfair, deceptive, or unlawful. The provision is facially valid, the court stated, because its enforcement is subject to traditional contract defenses like unconscionability and other limitations such as the requirement that Health Plan's claim be reduced to account for attorney's fees expended by the member in obtaining the recovery.

The court's other principal holding was that the trial court's order improperly infringed on the California legislative scheme for regulating HMOs by basing a violation of § 17200 on a finding of unlawfulness under certain sections of the Knox-Keene Act. These sections, the court held, did not define any unlawful acts, but rather

delegated and mapped out an on-going administrative responsibility for the California Department of Corporations. A statute that does not itself define unlawfulness, the court concluded, cannot be the basis for a violation of the unlawfulness prong of § 17200.

The Court of Appeal drew a similar conclusion with respect to the federal HMO Act. The court did not determine whether Health Plan's TPL provision may be the object of administrative action under the HMO Act. The court simply decided that the Act could not be used as a standard for finding a violation of § 17200 because there is "nothing in the statute or related regulations that declares a third party liability provision to be unlawful as a matter of substantive law." (App. 23). This holding is based on the Court of Appeal's interpretation of the "unlawfulness" prong of a *state* statute, *viz*, § 17200.

Petitioner's request for review by the California Supreme Court was denied.

REASONS FOR DENYING THE WRIT

Many reasons exist for denial of the present petition for writ of certiorari. Respondents limit this opposition to three reasons, each of which compels denial of the petition. First, there is no substantial federal question presented. Second, the decision of the California Court of Appeal rests exclusively on adequate and independent state grounds. Third, even if the Court determines that review is warranted as to the interpretation of the federal HMO Act, the Court should remand the case to the California Court of Appeal so that that court may decide whether § 17200 may be used to enjoin violations of the Act, an issue that court did not reach.

I.

THE PETITION PRESENTS NO FEDERAL QUESTION BECAUSE THE DECISION BELOW RESTS PRIMARILY ON INTERPRETATION AND APPLICATION OF A CALIFORNIA STATUTE.

The real issue posed by the present petition turns on an interpretation of a California state statute — not an interpretation of the federal HMO Act. There is no dispute that the federal HMO Act does not directly prohibit TPL provisions. Petitioner has always argued that such a prohibition should be *implied* from the goals of the federal statute and statutory provisions which do not expressly address the propriety of TPL provisions. In rejecting petitioner's federal HMO Act theory, the Court of Appeal did not probe and resolve the parties' debate over the correct, implied meaning of the Act. Rather, the Court of Appeal simply held that the "unlawfulness" prong of § 17200, California Business and Professions Code, can be invoked only on the basis of an explicit statutory prohibition, a prohibition that is nowhere to be found in the federal HMO Act. Because this holding is based on an interpretation of a California statute, the petition does not present a substantial federal question.

By its principal holding, the Court of Appeal merely added to the well-developed jurisprudence of California's unfair business practices laws the logical principle that the unlawfulness prong of § 17200 "borrows" only statutes and regulations which specifically declare certain conduct to be unlawful. The federal HMO Act and its implementing regulations by their terms do not declare TPL provisions unlawful. Therefore, the Court of Appeal reasoned, § 17200 cannot "borrow" the Act to enjoin TPL provisions as unlawful business practices.

Before the Court of Appeal, petitioner argued that previous

§ 17200 cases had allowed relief under that section to combat practices that were also subject to administrative enforcement under the "borrowed" statute or regulation. According to petitioner, the existence of a dual enforcement mechanism did not preclude a court from finding and rectifying a violation of § 17200. The Court of Appeal, however, explained that such dual enforcement may be allowed, and § 17200 invoked, only where a statute or regulation expressly prohibits specified conduct. The court accordingly held that § 17200 cannot be used to enforce a statute or regulation that does not define unlawful conduct but rather sets out guidelines and objectives that govern the administrative agency's exercise of its discretionary enforcement powers.

The Court of Appeal declared that courts cannot, in the guise of enforcing § 17200, construe the applicable statutes or regulations to achieve their regulatory objectives when that task has been expressly delegated to an administrative agency. If and when the agency promulgates a regulation declaring certain conduct unlawful, that regulation can then serve as a basis for § 17200 relief. Until the agency does so, however, a court cannot do so merely by the authority of § 17200.

The Court of Appeal did not interpret or apply the federal HMO Act. As it did in its review of the Knox-Keene Act, the Court of Appeal merely looked to see if TPL provisions are explicitly outlawed by the HMO Act and its implementing regulations. Nothing in the federal Act prohibits TPL provisions. HHS has chosen neither to mandate nor prohibit them in its regulations. The Court of Appeal, therefore, concluded that the Act did not provide a basis for finding that the TPL provision is an unlawful business practice under § 17200.

The HMO Act was involved in the case below only to the extent petitioner sought to use it as a standard for application of a

state statute, § 17200. Petitioner did not seek to enforce the Act, which he may not do in any event, since it provides neither an express nor an implied private right of action. *E.g., Health Care Plan, Inc. v. Aetna Life Ins. Co.*, 966 F.2d 738 (2d Cir. 1992); *UAW v. Ring Screw Works*, 741 F. Supp. 660, 663 (E.D. Mich. 1990). Petitioner's attempt to circumvent this prohibition through § 17200 does not create a federal question.

The case below has no effect on administrative enforcement of the Act, because the Court of Appeal specifically deferred to HHS for interpretation and enforcement of the Act. The case also has no effect on claims brought under other statutes that are claimed to "borrow" the HMO Act. Indeed, the case does not preclude future claims under § 17200 seeking to "borrow" the Act to the extent that it does define unlawful activity. The issue resolved by the Court of Appeal was a very narrow question of state law. The case below therefore does not present a substantial federal question.

II.

THE COURT OF APPEAL'S DECISION RESTS ENTIRELY ON ADEQUATE AND INDEPENDENT STATE GROUNDS RELATED TO INTERPRETATION AND APPLICATION OF § 17200.

For the reasons described above in Point I., the only ground necessary for the Court of Appeal's decision below was the court's interpretation of the unlawfulness prong of § 17200. The federal HMO Act was invoked by petitioner and summarily addressed by the Court of Appeal merely as a possible standard for application of § 17200 to the TPL provision. On the basis of its general holding as to the types of statutes and regulations on which a violation of § 17200's unlawfulness prong may rest, the Court of Appeal affirmed the trial court's finding that the Act did not provide such a standard.

Thus the Court of Appeal based its decision on California's § 17200. There are no federal grounds at all for the decision, let alone any "inextricably interwoven" with state grounds. Since it is thus "clear from the opinion itself" that the Court of Appeal relied upon an adequate and independent state ground and that it did not rest its decision "primarily on federal law," there is no basis for the Court to review the decision by writ of certiorari. *See Michigan v. Long*, 463 U.S. 1032 (1983).

Petitioner acknowledges that the federal HMO Act does not provide an implied private right of action. That the federal Act is enforceable only by HHS reinforces the fact that petitioner merely sought to use the Act as a standard for application of § 17200. Petitioner sued under § 17200 and lost because of the Court of Appeal's interpretation of this state statute.

III.

IF THE COURT DETERMINES THAT REVIEW IS WARRANTED REGARDING INTERPRETATION OF THE HMO ACT, THE COURT SHOULD REMAND THE CASE FOR DECISION ON WHETHER VIOLATIONS OF THE ACT ARE ENJOINABLE UNDER § 17200.

Even if the Court determines that a federal question is presented that may be worthy of review, the Court should send the case back to the California Court of Appeal for a decision as to whether violations of federal regulatory statutes are enjoinable under § 17200. The California Supreme Court has held that an inferior state court should ordinarily decline to enforce federal statutes which create regulatory schemes that are enforceable only by federal administrative agencies. *See Department of Transportation v. Naegele Outdoor Advertising Co.*, 38 Cal. 3d 509, 523, 213 Cal. Rptr. 247 (1985), *cert. denied*, 465 U.S. 1045 (1986) (§ 17200 injunction inappropriate for violation of federal

highway law that delegated authority to Department of Interior). The Court of Appeal specifically elected not to decide this issue. If, on remand, that court decides that the federal HMO Act is not enforceable under § 17200, the question posed by the present petition will be moot.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

Respectfully submitted,

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Supreme Court, U.S.
FILED
MAY 11 1994
OFFICE OF THE CLERK

No. 93-1502

In the Supreme Court of the United States

October Term, 1993

Arthur Bradley Samura,
Petitioner,

v.

Kaiser Foundation Health Plan, Inc.,
The Permanente Medical Group, Inc., and
Kaiser Foundation Hospitals, Inc.,
Respondents.

REPLY IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI TO THE CALIFORNIA COURT OF APPEAL, FIRST APPELLATE DISTRICT, DIVISION ONE

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I. INTRODUCTION.

Kaiser-Permanente's opposition to certiorari is not supported by any part of the decision of the court of appeal, by any other decision interpreting California's little FTC Act, Business and Professions Code § 17200, or by any other California law. Kaiser argues that the court of appeal held that the "unlawful" prong of § 17200 may be invoked only if it relates to an "explicit" or "express" statutory prohibition. In fact, these words do not appear in any pertinent part of the decision. The decision instead fully agrees with a uniform body of California law holding that the nature, scope and purpose of § 17200 is to enjoin *any* act or practice that violates substantive law.

This petition for writ of certiorari presents an important issue regarding heath services from hundreds of HMO to millions of HMO members, and the petition should be granted.

II. THE FEDERAL QUESTION IN THIS PETITION WAS NOT DISPOSED OF ON INDEPENDENT STATE LAW GROUNDS.

A. The Petition Presents A Substantial Federal Question.

The federal question presented in the petition is whether the Health Maintenance Organizations Act, 42 U.S.C. § 300e, prohibits HMOs from imposing "Third Party Liability" surcharges in addition to member dues, that is, charges at Non-Member Rates to members for each service actually furnished in addition to prepaid monthly dues when members are injured by third parties who financially compensate them.

Petitioner claims that the HMO Act on its face, 42 U.S.C. § 300e(b)(1), prohibits TPL charges. This provision

of the HMO Act states a general rule requiring that HMOs shall provide health care in exchange for prepaid periodic charges *only*, and then the Act enumerates certain exceptions to the general rule. Because Congress set forth a general rule, then set forth certain exceptions only, additional exceptions may not be read into the HMO Act. Petitioner's HMO Act claim is grounded entirely on the language and structure of the HMO Act itself; in other words, petitioner claims that TPL charges are not allowed as a matter of substantive law, correctly interpreted.

The California court of appeal erroneously interpreted the HMO Act not to bar TPL charges "as a matter of substantive law." App. 22-23. Then, the court of appeal held that petitioner could not base a § 17200 claim on the federal HMO Act because the Act did not bar TPL charges. App. 22-23.

The decision is not based on a holding that § 17200 only reaches acts that are "explicitly" prohibited, as Kaiser argues. Rather, the court of appeal reaffirmed that any act that is unlawful may support a challenge based on § 17200. The court of appeal held that trial courts should refrain from deciding § 17200 claims if they rely on a regulatory provision that confers an agency with discretion, if the agency has not exercised its discretion. App. 18-19.

Thus, had the California court of appeal concluded (as it should have) that the HMO Act does not allow TPL charges, and that Congress did not confer any discretion on the Secretary of the Department of Health, Education and Welfare, or its successor, the Department of Health and Human Services, to approve TPL charges, the court of appeal would have found a violation of § 17200. *See* App. 18-19. The decision on the federal question rests entirely on the court's erroneous conclusion that TPL charges are not unlawful in light of the federal HMO Act as a matter of federal substantive law. The decision does not rest on an independent state grounds.

B. Petitioner's HMO Act Claim Is Not Based On An "Implied" Policy Of The HMO Act.

The first step in Kaiser's effort to avoid certiorari is its assertion that petitioner agrees with Kaiser that the HMO Act does not directly prohibit TPL provisions, and Kaiser's assertion that petitioner has always argued that such a prohibition should be "implied from the goals of the federal statute . . ." *See* Kaiser's opposition, p. 5.

Actually, petitioner's claim rests on the structure and content of the statute, and on the application of the well-established rule of statutory construction, *inclusio unius est exclusio alterius. Andrus v. Glover Construction Co.*, 446 U.S. 608, 616-617 (1980). Further, the prohibition against TPL terms is repeated in the HMO Act's regulations. 42 C.F.R. § 417.102(e), emphasis added; *see id.* at § 417.104(a).[1]

Both the HMO Act and its regulations prohibit HMOs from charging Non-Member Rates to members through TPL terms because the HMO Act does not allow charges based on the frequency, extent or kind of services actually furnished.

C. Petitioner's Claim Is Consistent With The Scope And Purpose Of § 17200.

The second step in Kaiser's attempt to avoid certiorari is its attempt at creating the illusion of an independent state law ground for the court of appeal's decision on the HMO Act. Kaiser argues the existence of

[1] Kaiser also errs by relying on the testimony of one of its witnesses, a former lower echelon federal employee who testified about what Congress intended when it amended the HMO Act in 1978, and about what HEW intended when it promulgated certain regulations in 1974. The testimony was irrelevant and incompetent.

a technical requirement to § 17200 that does not exist, and that is inconsistent with the nature, scope, purpose or history of § 17200. Kaiser's contention could not be further from the law of § 17200.

1. A § 17200 injunction is not limited to "explicitly" prohibited conduct.

Section 17200 broadly defines "unfair competition" to include "*any unlawful*, unfair or fraudulent business *act* or practice." (Emphasis added.)

In *Barquis v. Merchant's Collection Assn.*, 7 Cal.3d 94 (1972), the California Supreme Court explained: "The language of [§ 17200] . . . explicitly extends to any 'unlawful, unfair *or* deceptive business practice'; the Legislature, in our view, intended by this sweeping language to permit tribunals to enjoin on-going wrongful business conduct in whatever context such activity might occur. " *Id.* at pp. 111-112, original emphasis.

The California Supreme Court recently reviewed the scope and purpose of § 17200, and the Court reaffirmed that § 17200's scope includes anything that can properly be called a business practice and that at the same time is forbidden by law. *Bank of the West v. Superior Court*, 2 Cal.4th 1254, 1266 (1992).

Neither the statute itself, nor the cases interpreting it, limit the scope of § 17200 to business practices that are "explicitly" forbidden by law.

2. The decision held that § 17200 reaches any unlawful acts.

The court of appeal did not distinguish the California Supreme Court decisions on § 17200, nor did it add a requirement that a challenged business practice be "explicitly" forbidden by law. *Cf.* Kaiser's opposition p. 5.

The decision below affirms that petitioner may rely on the substantive laws and regulations of any statutory enforcement scheme to supply the predicate "unlawful" practice within the meaning of § 17200. The decision unequivocally affirms the well-established rule that "An 'unlawful business activity' includes 'anything that can properly be called a business practice and that at the same time is forbidden by law.'" App. 6-7; *see also* 18-19.

Instead, the court of appeal rejected petitioner's HMO Act claim based solely on that court's conclusion that TPL terms and charges are not prohibited by the HMO Act as a matter of its interpretation of the federal HMO Act. App. 23. Whether the HMO Act allows TPL charges is the ultimate issue presented by this petition.

3. § 17200 may use statutes that do not have a private right of action.

Kaiser also argues that the lack of an express or implied private right of action in the federal HMO Act precludes § 17200 from borrowing the HMO Act as a standard. Kaiser's opposition, p. 7. However, the California Supreme Court long ago rejected the contention that the lack of a private right of action limits § 17200's ability to borrow the standards in other laws or regulations. In *Committee on Children's Television v. General Foods Corp.*, 35 Cal.3d. 197 (1983), the California Supreme Court noted that the parties "vigorously dispute" whether there was a private right of action in the state law, "but the question is immaterial since *any* unlawful business practice, including violations of the Sherman law, may be redressed by a private action charging unfair competition in violation of Business and Professions Code sections 17200 and 17203." *Id.* at pp. 210-211 (emphasis added). The court of appeal in this case did not even contend that the federal HMO Act does not provide a private cause of

action. *See* App. 23. Instead, the decision fully agrees with the well-established rule that a parallel action under § 17200 is proper even where a specific agency has been charged with enforcement of a statute.[2] App. 18-19.

4. Kaiser attempts to cloud the issue by interposing unique aspects of the Knox-Keene Act .

Kaiser's first argument below was that the Department of Corporations, had approved Kaiser's TPL term. The court of appeal disagreed. The court decided that the Department had not determined whether, or to what extent, TPL terms were lawful under the Knox-Keene Act. App. 10-11. The court also stated that the "matter plainly calls for legislative or regulatory action." App. 17, n. 5.

The court of appeal agreed with Kaiser's second argument, one unique to the Knox-Keene Act, and not transportable to the federal HMO Act, the California Legislature conferred exclusive regulatory power over HMOs to the Department of Corporations. *See, Van de Kamp v. Gumbiner*, 221 Cal.App.3d 1260 (1990). *Gumbiner* arose because the Attorney General and the Department developed conflicting definitions for self-dealing by HMOs, and HMOs could not satisfy both. The court of appeal reversed the trial court's injunction because it depended on sections of the Knox-Keene Act that were "purely regulatory" in nature, and intruded on the Department's exclusive regulatory power. App. 18, 22.

[2] Neither the federal HMO Act nor California's HMO Act, Calif. Health & Saf. Code § 1340 et seq. the "Knox-Keene Act," confer a private cause of action. The court of appeal nonetheless held that Samura could "sue to enjoin acts made unlawful by the Knox-Keene Act." App. 18-19.

The rationale was that the Department had not exercised its discretion regarding its regulatory power on the matters encompassed by the trial court's injunction.

Notwithstanding, the court of appeal's decision correctly holds that petitioner may base a § 17200 claim on any act or practice that is prohibited pursuant to the Knox-Keene Act or by the Department's regulations. App. 18.

Kaiser ignores several critical points in order to transmute the court of appeal's analysis of the Department's regulatory powers into a holding that § 17200 only reaches "explicit" violations of law. *See* Kaiser's opposition p. 6.

First, the court of appeal held that petitioner could use § 17200 to enjoin acts or practices that are unlawful under the Knox-Keene Act or the Department's regulations, so long as his § 17200 claim rested on a provision that defined unlawful acts or practices, rather than on a purely regulatory provision about which the Department has not exercised it discretion. App. 18, 22.[3] Second, the court of appeal's analysis regarding "purely regulatory" provisions plainly involves issues unique to the Knox-Keene Act and the California Legislature's decision to entrust the Department with exclusive power to define and regulate HMO conduct in order to avoid conflicting regulations.

Here, the federal HMO Act itself makes TPL charges unlawful. 42 U.S.C. § 300e(b)(1). The HMO Act's prohibition against TPL charges is not a purely regulatory guideline, it is a Congressional statement of substantive

[3] This portion of the holding follows the principles explained in *People v. McKale*, 25 Cal.3d 626 (1979) where the California Supreme Court ruled that § 17200 specifically may be used to enjoin violations of law despite a parallel enforcement scheme. *McKale*, *supra* at p. 633.

law. And, Congress did *not* grant the Secretary of HEW or HHS any discretionary power to create additional exceptions to the HMO Act's general rule. *See* S.REP.NO. 95-837, 97th Cong., 1st Sess. 9-10. Thus, the HMO Act defines TPL charges as unlawful. Finally, the HMO Act and its regulations provide that the states are to adopt and enforce the HMO Act's standards. *See* S.REP.NO. 100-204, 100th Cong., 2nd Sess. p. 11.

The California court of appeal recently applauded a private attorney general suit based on § 17200 seeking to prevent an HMO from violating Medicare regulations: "Congress clearly recognized the need for state and local assistance in regulating the marketing of HMO's and other supplemental health care packages to the elderly and disabled, and, quite the opposite of intending preemption, appears to have intended a call to the states (and private parties) for all the help it can get." *Solorzano v. Superior Court*, 10 Cal.App.3d 1135, 1149 (1992). Similarly, a § 17200 suit that borrows the standards of the HMO Act furthers the objectives of the HMO Act.

In sum, the federal HMO Act may supply the standard for § 17200.

D. The Preemptive Effect Of The Federal HMO Act Presents A Federal Question.

Kaiser's last argument is that § 17200 may only be used to enjoin violations of state law. *See* Kaiser's opposition pp. 8-9. However, as a matter of state law, § 17200 may be used to enjoin *any* violation of law, including violations of federal laws. *Farmers Ins. Exchange v. Superior Court*, 2 Cal.4th 377, 395 (1992); *Bank of the West v. Superior Court*, 2 Cal.4th 1254, 1264 (1992); Calif. Bus. & Prof. Code § 321 prohibits a "violation of any law of this state or any federal law . . . ."

Section 17200 reaches violations of federal law unless limited by federal preemption. Thus, injunctions will not issue under § 17200 where Congress has occupied the field, or where an injunction would conflict with the objectives of federal law. *See Solorzano v. Superior Court, supra*, 10 Cal.App.4th 1135 explaining that injunctive relief was denied in *People ex rel. Dept. of Transportation v. Naegele Outdoor Advertising Co.*, 38 Cal.3d 509 (1985) and *Diaz v. Kay-Dix Ranch*, 9 Cal.App.3d 588 (1970) because both cases "deal with fields absolutely and entirely preempted by federal law (immigration and Indian affairs.)" *Solorzano v. Superior Court, supra* at p. 1148, n. 14.) Where there is no preemption, violations of federal law may be enjoined based on § 17200. *See, People v. Highland Sav. & Loan Assn.* 14 Cal.App.4th 1692 (1993).

Federal regulations may also be "borrowed" to set the standards for § 17200 claims. California law looks to Federal Trade Commission's rules and regulations as "more than ordinarily persuasive" in guiding the California courts construing § 17200. *People ex rel. Mosk v. National Research Co. of Calif.*, 201 Cal.App.2d 765, 772-773 (1962); *O'Conner v. Superior Court*, 177 Cal.App.3d 1013, 1018 (1986).

Kaiser's argument that this case should be remanded before this Court reaches the merits of the petition, so that the court of appeal may decide whether the HMO Act preempts the application of § 17200, is without merit because the state court's decision on preemption is not a prerequisite to certiorari. Instead, the preemptive effect of the HMO Act (an effect that is extremely narrow) presents a federal question that is properly decided by this Court in the first instance.[4] *See Morales v. Trans World*

[4] Essentially the HMO Act preempts only those state laws that prevent the formation or operation of federally qualified HMOs. *See* 42 U.S.C. § 300e-10.

Airlines, Inc., ___ U.S. ___; 112 S.Ct. 2031; 119 L.Ed.2d 157 (1992).)

III. CONCLUSION.

This petition concerning the correct interpretation of the HMO Act presents a substantial federal question that affects hundreds of HMOs and many millions of their members. Petitioner respectfully requests that his petition for a writ of certiorari be granted.

MAY 1994

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